Is there a relationship between trauma, PTSD and negative symptoms of psychosis?

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Case study I:

A diagnostic puzzle: assessment of a 6 year old girl with sexualised and aggressive behaviour

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Case Study I: Contents

1. 1 Introduction

1.1.1 Looked after children and diagnostic challenges

Diagnosis within child clinical practice aims to provide an accurate description of the child's difficulties to inform treatment. This however can be fraught with difficulty, particularly within the 'looked after' child(ren) (LAC) population. De Jong (2010), for example, argues LAC clinical presentations tend to be atypical compared to routine Child and Adolescent Mental Health Service (CAMHS) cases and are characterised by complexity, posing significant challenges for diagnosis and treatment recommendations. De Jong (2010) further argues the DSM-IV inadequately captures both the range and type of psychopathology observed in the LAC population. De Jong (2010) highlights how a 'complex combination of pre-natal influences, interpersonal trauma surrounding the primary care giving relationship, disturbed and disrupted attachment relationships, significant losses and adverse environmental effects' combine to produce a complex constellation of symptoms and a pervasive impact on development which can be difficult to categorize. If the range and type of psychopathology observed in LAC are not adequately recognised by the diagnostic classification system this indicates oversimplified descriptions of these children's presentations may be propagated, along with incomplete treatments. Consequently, services may be failing to meet these children's needs.

1.1.2 Comorbidity and sub threshold presentations

Many disorders such as conduct disorder, attention deficit hyperactivity disorder (ADHD), Posttraumatic stress disorder (PTSD), depression and anxiety may form part of a co-morbid picture in the LAC population (De Jong, 2010). Additionally, these co-morbidities may manifest in multiple sub-threshold presentations, which further complicates reaching an adequate diagnosis (Pincus, McQueen & Elinson, 2003). This becomes an issue when the resulting profile is more functionally impairing than the diagnostic profile indicates, especially when sub-threshold difficulties are not treated because they are not represented by a diagnosis (De Jong, 2010). This is particularly concerning as research indicates sub-threshold presentations tend to escalate into full-blown disorders (Shankman et al., 2009) and suggests early intervention opportunities are being overlooked. It is also debatable whether the resulting 'picture' is best conceptualised by multiple disorders which retain their distinct qualities or by combining

them (De Jong, 2010). Oswald, Heil, & Goldbeck (2010) argue applying comorbidity to children exposed to persistent and multiple trauma merely fragments a cohesive developmental disorder and ignores the pervasive impact that multiple childhood traumatisation has on psychobiological development.

1.1.3 Maltreatment

Maltreatment is an umbrella term including sexual, physical and emotional abuse and neglect (DOH, 2006) and has pervasive and diffuse consequences (WHO, 2014). LAC by definition infers these children have been subject to adverse experiences within the primary care giving relationship, often during formative times in development. Evidence suggests such maltreatment can significantly alter a child's normal developmental trajectory and result in neuropsychological sequalae (McRory, DeBrito & Vising, 2010) leaving the child with significant long-term impairments that can manifest throughout childhood and adulthood (Stirling & Amaya-Jackson, 2008).

1.1.4 Sexualised behaviour and child sexual abuse (CSA)

Sexualised behaviour has been linked to CSA as well as maltreatment, family dysfunction, parenting deficits and other developmental difficulties and does not necessarily infer that the child has been sexually abused, consequently sexualized behaviour requires contextual understanding (Tarren-Sweeny, 2008). CSA is however a common phenomenon which is known to have long lasting, deleterious psychological effects (Kings et al., 2000) and is associated with the development of various mental health problems and interpersonal difficulties (Banyard, Williams & Siegal, 2001).

1.1.5 Attachment difficulties vs. autism spectrum disorder (ASD)

The relationship between attachment difficulties and autism spectrum disorders (ASD) is unclear (Volkmar, State & Klin, 2009). Rutter et al. (2007) and Moran (2010) emphasise the difficulty distinguishing whether a child has attachment problems, ASD or both, when they have experienced adverse early life experiences, serious abuse or trauma. This is because the presenting social, emotional and behavioural difficulties may appear very similar or overlap in these children (Moran, 2010). This has led Moran (2010) and colleagues to develop 'The Coventry Grid' which conceptualises behavioural patterns that may help differentiate between ASD and significant attachment problems. Moran (2010) also argues a bias exists to understand LAC's behaviour through attachment difficulties rather than ASD, despite indications that the rates of ASD are higher in this

population than in the general population (Baron-Cohen et al., 2009). Conversely, others argue that more children with significant attachment difficulties exist than are diagnosed due to the stringent attachment disorder criteria (Howe, 2006).

1.2 Case description

1.2.1 Presenting problem

Hannah (re-named for case study) was a 6-year-old girl who was taken into care after presenting with extreme sexualised and aggressive behaviour which school had found difficult to manage, resulting in her being excluded. Her behaviour raised concerns that she was a victim of sexual abuse and about the ability of her carers to keep her safe. Hannah and her family were consequently referred for a multidisciplinary child care assessment as part of child care proceedings, to better understand Hannah's behaviour and needs. The assessment began three months into Hannah's foster care placement and two months into her new school placement. The questions used to guide the assessment from the solicitors' letter of instruction are detailed in appendix A. My role was to assess the child whilst other team members assessed the adults. The assessment followed the five-stage process of 'The Maudsley Model of Parenting Assessments', outlined in appendix B.

1.2.2 Family network

Hannah was the only child in her family network and because her Mother experienced severe depression in Hannah's early years her maternal Grandmother shared her care. Hannah did not have contact with her Father but was in regular contact with her Grandmother's long-term ex-partner for much of her childhood.

1.2.3 History

Hannah began to demonstrate extreme sexualised and aggressive behaviour towards teachers and other children from 4 years of age. This included kicking, punching and biting teachers and other children. Hannah would often demonstrate and describe sexual acts and ask others to engage in sexually themed 'play' with her. The content of this conveyed a detailed level of sexual knowledge beyond what would be expected from exposure to sexualised material, leading to concerns that Hannah had been subject to some form of sexual abuse. Her challenging behaviour led to multiple school exclusions. These concerns eventually resulted in Hannah being placed in foster care and a pupil

referral unit (PRU) until she was admitted to a therapeutic school. Hannah's young age and the extreme nature of her challenging behaviour caused anxiety and indecision within her surrounding systems, which may have contributed to Hannah's behaviour and the delay in intervention.

1.3 Aim

The case study aims to highlight the clinical challenges encountered when considering differential diagnosis and developing a formulation within the LAC population.

1.3.1 Clinical hypothesis for assessment

To assess whether Hannah's challenging behavior was due to an underlying pervasive developmental disorder or due to experiences of sexual abuse, or the combined impact of these separate influences.

1.4 Design

The design involved a comprehensive, multi-systemic assessment of Hannah's challenging behaviour over time and contexts to aid formulation. The comprehensive nature of the assessment was vital given the nature of the abuse (likely to have been invasive sexual abuse occurring from an early developmental stage, possibly within a caregiving relationship) and the pervasive and diffuse impact. Clinical interviews, structured assessments and observations were employed to achieve this. Various questionnaire measures were also administered to Hannah's Mother, Foster Carer and her current Teachers to triangulate information about Hannah's challenging behaviour. This provided a holistic picture of Hannah's problems across different areas.

1.5 Assessment

The assessment measures employed to conduct the assessment are outlined in table

Table 1: assessment measures employed to aid the assessment of Hannah's challenging behaviour

Assessment/measure	***Reference/protocol***
A cognitive assessment using the WISC IV	The Wechsler Intelligence Scale for Children – Fourth addition (2004)
A test of attainment using the WIAT II	The Wechsler Individual Achievement Test II Wechsler (2005)
The Autism Diagnostic Interview-Revised	ADI-R: Rutter, LeCouteur & Lord, (2003)
The Autism Diagnostic Observation Schedule	ADOS, Lord, Rutter, DiLavore & Risi, (1999)
The Adaptive Behaviour Assessment System-Second Edition	ABAS-II, Harrison & Oakland, (2003)
The Social Communication Questionnaire	SCQ, Berument, Rutter, Lord, Pickles & Bailey (1999)
The Strengths and Difficulties Questionnaire	SDQ, Goodman, (1997).
Conners 3rd addition	Conners, (2008)
Interviews with members of the family network	CCAT Interview protocol
Interviews with schools	CCAT Interview protocol
Interview with the Foster Carer	CCAT Interview protocol
Psychology interviews with Hannah	CCAT Interview protocol
Contact Observations with her Mother and Grandma, separately and together	CCAT Contact observations protocol

1.5.1 Cognitive assessment: cognitive-verbal discrepancy

A cognitive assessment was conducted as a matter of course and revealed Hannah had a variable cognitive profile, best considered in terms of strengths and weaknesses. Her verbal comprehension skills fell in the superior range compared to other young people her age. However, the majority of her remaining scores across perceptual reasoning, working memory and processing speed, fell in the borderline to low average ranges. Hannah's superior verbal comprehension skills were likely to mask her overall low average ability. This may have led others to perceive Hannah as more able than she is which was likely a frustrating experience for Hannah, particularly when she was trying to learn new information and may have contributed to her challenging behaviour at school.

Throughout the assessment Hannah demonstrated that she relied heavily on her advanced language skills and absorbed language readily. The finding that Hannah possessed superior language skills also had implications for the way in which professionals interpreted Hannah's descriptions of sexual incidents. Additionally, during the assessment we noted Hannah used repetitive, mannerist, parroting of adult-like phraseology and neologisms, which led to the team assessing Hannah for ASD.

Table 2: Hannah's WISC IV standard scores and descriptions

Indices	***Standard Score***	***95% Confidence Interval***	***Percentile***	***Description***
Verbal Comprehension	124	116-129	95	Superior
Perceptual Reasoning	92	85-100	30	Average
Working Memory	80	74-89	9	Low Average
Processing Speed	73	67-85	4	Borderline
Full Scale	91	87-97	30	Average Not Interpretable

Table 3: Hannah's WISC IV scaled subtest scores

Verbal comprehension	***Scaled scores***	***Perceptual reasoning***	***Scaled scores***
Similarities	14	Block design	4
Vocabulary	13	Picture concepts	14
Comprehension	15	Matrix reasoning	8
Working memory	Scaled scores	Processing speed	Scaled scores
Digit span	6	Coding	5
Letter number sequencing	7	Symbol search	5

1.5.2 Academic attainment

The WIAT indicated academically Hannah was performing in line with a borderline/ low average level of functioning. As her challenging behaviour precluded her from consistent access to education it was difficult to establish whether the disruption or learning difficulties account for her level of attainment.

1.5.3 The adaptive behaviour assessment system-second edition (ABAS-II)

The ABAS-II (Harrison & Oakland, 2003) is an informant questionnaire that provides a comprehensive, norm-referenced assessment of a child's functional skills and adaptive behaviour in various areas of everyday life. The ABAS-II was administered to enable the comparison between Hannah's adaptive skills and the adaptive skills of a typically developing young person of the same age and how Hannah's adaptive skills differed across foster care and school settings. Hannah's Foster Carer scored Hannah's current ability on all subtests as falling within an 'average' range, suggesting that from her perspective Hannah's ability across areas was in line with other children her age. On a subtest level her current Head Teacher also scored Hannah as falling in the 'average' range for communication, functional academics, leisure, self-care, self-direction and social skills. However, he scored Hannah as falling in the 'below average' range for school living and health and safety skills and in the 'extremely low' range for community use skills, indicating some clear problem areas.

Table 4: Scaled scores for Hannah's current adaptive skills by her Foster Carer and her current Head Teacher

Skill area	***Scaled score foster carer***	***Description***	***Scaled score school head teacher***	***Description***
Communication	8	Average	8	Average
Community use	9	Average	1	Extremely low
Functional academics	8	Average	11	Average
Home living	9	Average	7	Below average
Health and safety	13	Average	6	Below average
Leisure	14	Average	11	Average
Self-Care	8	Average	10	Average
Self-Direction	9	Average	8	Average
Social	13	Average	10	Average

The ten subtest skill areas are grouped together to provide a general adaptive composite that is used as an estimate of overall adaptive functioning. They are also grouped together to form four derived composite summary scores so that patterns of ability in different areas can be compared. Hannah's Foster Carer scored Hannah as currently functioning in the 'average' range across composites and 'above average' on the social composite. Hannah's school also rated her current functioning in the 'average range' for the majority of composites, apart from the practical composite where Hannah fell in the 'below average' range compared to similar aged peers.

Table 5: Current composite scores in foster care (completed by Foster Carer)

Composite	***Composite score***	***95% Confidence interval***	***Percentile rank***	***Qualitative description***
General adaptive composite	102	98-106	55.3	Average
Conceptual	91	86-96	27.4	Average
Social	117	110-124	87.1	Above Average
Practical	99	93-105	47.3	Average

Table 6: Current composite scores from school (completed by Head Teacher)

Composite	***Composite score***	***95% Confidence interval***	***Percentile rank***	***Qualitative description***
General adaptive composite	90	87-93	25.2	Average
Conceptual	99	94-104	47.3	Average
Social	104	99-109	60.5	Average
Practical	84	79-89	14.3	Below Average

1.5.4 The social communication questionnaire

The Social Communication Questionnaire (SCQ) is an informant questionnaire measure which helps to assess communication skills and social functioning in children who may have an autism spectrum disorder (ASD). The 'Lifetime' version focuses on the child's entire development, providing a total score, which indicates that the child may have an ASD and requires further assessment if it is above 15. Hannah's Mother scored Hannah

21 on this questionnaire, suggestive of developmental difficulties with social communication, which may be consistent with ASD. The 'Current' form looks at the child's behaviour over the most recent 3-month period; the cut off for significance on the current SCQ is 11. Hannah fell below the threshold as rated by her Foster Carer at 3 and Head Teacher at 7.

As the lifetime SCQ indicated developmental difficulties in social communication, Hannah was assessed using the Autism Diagnostic Interview-Revised (ADI-R, Rutter, LeCouteur & Lord, 2003) and The Autism Diagnostic Observation Schedule (ADOS, Lord, Rutter, DiLavore & Susan Risi, 1999) which resulted in a diagnosis of Atypical Autism. The discrepancy between her scores on the current SCQ and the lifetime SCQ and positive diagnostic assessments suggested that Hannah's difficulties were subtle and their expression were possibly mediated by her social environment and complicated by other factors.

Table 7: Scores on the SCQ

SCQ- Lifetime Hannah's Mother	***SCQ - Current Foster Carer***	***SCQ - Current School***
21	3	7

1.5.5 The strengths and difficulties questionnaire

The Strengths and Difficulties Questionnaire (SDQ) is a brief informant behavioural screening questionnaire about 4-16 year olds. It asks about 25 positive or negative attributes, which are divided between five scales: emotional, conduct, hyperactivity/inattention, peer relationship problems and pro-social behaviour. Four of these (excluding prosocial) are then added together to generate a total difficulties score. The SDQ was administered to Hannah's Mother, Foster Carer and current Teacher to determine patterns of difficulties.

Overall, Hannah's mother rated her current total difficulties in the 'abnormal' range, indicating that she experiences difficulties in conduct problems, hyperactivity and peer relations to an abnormal degree and that her prosocial skills are in the 'borderline' range. Hannah's emotional symptoms however were rated in the normal range. Hannah's Foster Carer also rated Hannah's total difficulties in the 'abnormal' range along with conduct and peer problems. Her Foster Carer however rated Hannah's emotional symptoms, hyperactivity and pro-social skills in the 'normal' range. Conversely, Hannah's current school rated her total difficulties as falling in the 'normal' range with peer problems as the only area within the 'abnormal' range. Overall this indicated Hannah had significant difficulties with conduct and peer relations but that her behaviour seemed to be managed well in her current school.

Table 8: Hannah's SDQ scores and descriptions by her Head Teacher, Foster Carer and Mother

Domain	***Current School***	***Mother when in her care***	***Foster carer***
Total difficulties score	8 Normal	22 Abnormal	8 Abnormal
Emotional symptoms score	0 Normal	2 Normal	0 Normal
Conduct problem score	0 Normal	7 Abnormal	7 Abnormal
Hyperactivity scale	4 Normal	9 Abnormal	5 Normal
Peer Problems scale	4 Normal	4 Abnormal	6 Abnormal
Prosocial scale	8 Normal	5 Borderline	6 Normal

1.5.6 Conner's questionnaires

The Conners 3 (Conners, 2008) is an assessment of Attention-Deficit and Hyperactivity Disorder (ADHD) where scores above 70 are considered clinically significant. Hannah's Mother completed a current parent report short version and an early childhood version. The Foster Carer also completed the current parent report short version. Additionally, Hannah's teacher completed the current teacher version. All short versions of the questionnaire reflect the child's behaviour over the last month. All questionnaires indicated that Hannah demonstrated elevated to very elevated levels of inattention,

hyperactivity/impulsivity, learning problems, defiance and aggression as well as difficulties with peer relationships and executive functioning across situations and caregivers.

Table 9: Conners early childhood GI-parent (completed by Mother)

Domain	***T score***
Restless-Impulsive	85**
Emotional Lability	84**
Total	88**

Table 10: Conners current questionnaires

Domain	***Parent report short – mother completed***	***Parent report short – foster carer completed***	***Teacher report current short (Completed by current class teacher)***
	T score	T score	T score
Inattention	85**	≥ 90**	82**
Hyperactivity/ impulsivity	88 **	88 **	≥ 90**
Learning problems	68*	72**	75**
Defiance/ aggression	60*	≥ 90**	≥ 90**
Peer relationships	≥ 90**	≥ 90**	≥ 90**
Executive functioning	74**	74**	74**

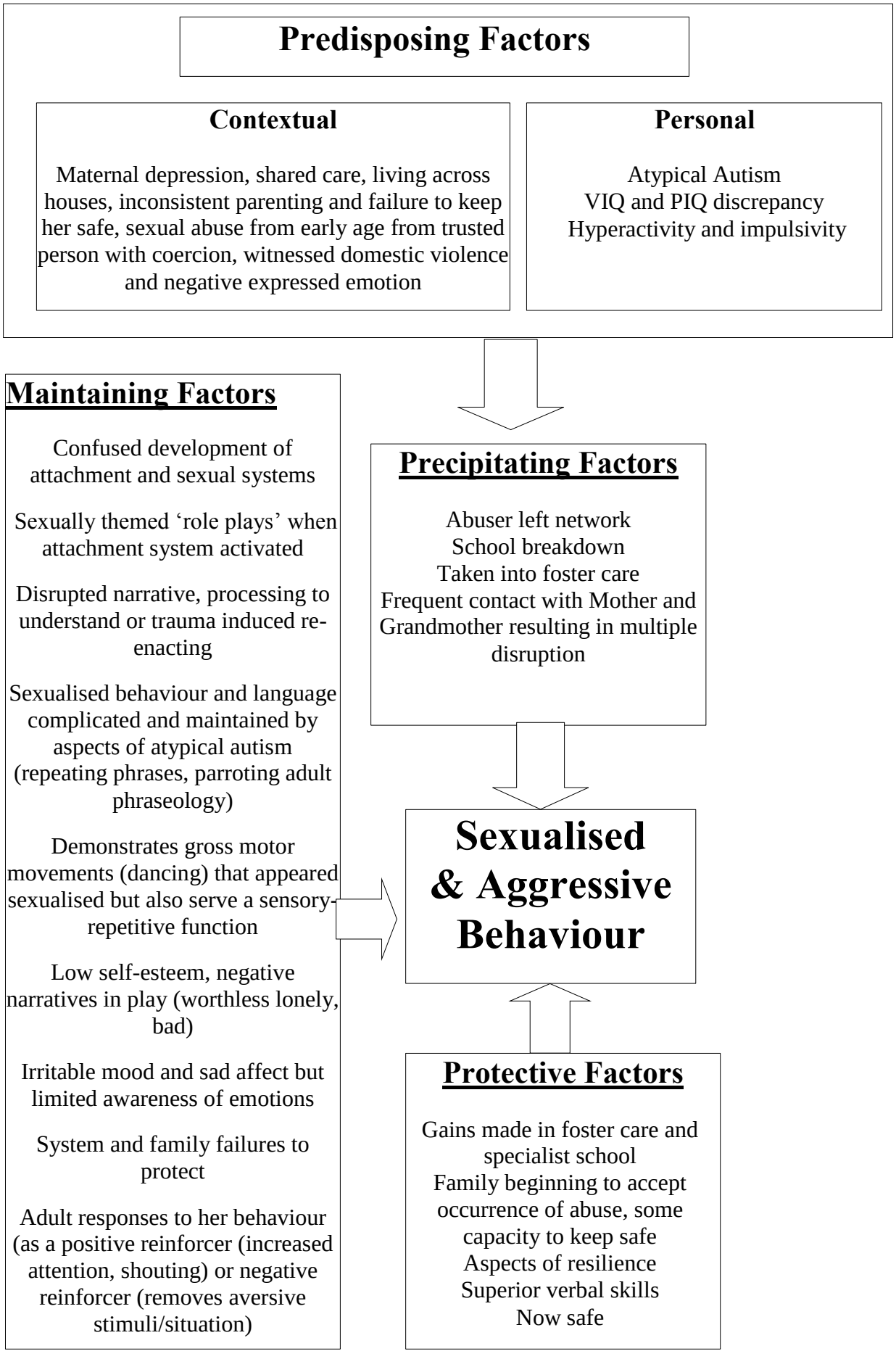
*=Elevated

**=Very Elevated

1.5.7 Inconsistencies when triangulating information

Throughout the assessment there were noticeable inconsistencies between reports of Hannah's behaviour by different individuals. This could either have been because Hannah's behavior was changeable across different contexts or that the informants interpreted her behaviour differently or were not able to provide accurate ratings of her behaviour. This highlights the importance of gaining information from multiple sources and observing the child in different settings so that accurate conclusions can be drawn from assessment.

1.6 Formulation



1.6.1 Autism spectrum disorder and possible hyperkinetic disorder

Hannah received a diagnosis of Atypical Autism from the ADI-R and the ADOS as she scored above the threshold on two domains (Qualitative abnormalities in reciprocal social interaction and communication) and below threshold in the third domain (Restricted, repetitive and stereotyped patterns of behaviour). Information gathered during the assessment also provided weight to this diagnosis, for example Hannah demonstrated sensory interests (sniffing, touching), sensory-repetitive gross motor movements, intense interest in a toy phone, language oddities, (repetitive, mannerist parroting of adult-phraseology and neologisms) and a poor understanding of social communication. Although Hannah met criteria for mild hyperkinetic disorder, the disruption to her life meant it was not currently appropriate to make this diagnosis without a stabilisation period in a settled, permanent caregiver setting and too early to advise treatment for ADHD.

1.6.2 Sexual abuse

Hannah displayed sexual knowledge and behaviour that was strongly suggestive of her being sexually abused. Hannah also made a disclosure of sexual abuse but then retracted this. This was accompanied with felt anxiety, sadness and 'worries' that the assessors would 'tell' someone (potentially the perpetrator), indicative of coercion. During the psychological interview Hannah involved the assessors in a role-play, which had sexual themes within a care context, for example asking to live with the assessor and then asking them to sleep in the same bed as her. There were several examples of this type of 'role-play' noted with other adults. The 'role-plays' may have served as a way for Hannah to communicate the very difficult experiences she had been subject to and could function as a way of her making sense of her experiences. They could also possibly have resulted from post-traumatic re-enactment. The role-play was powerful and the experience of being involved in it left the assessors, including myself, reflecting on the projection (Lanyado & Horne, 2009) of feeling powerless and to some degree abused, particularly due to the controlling nature of Hannah's behavior and the emotion evoked by the themes of abandonment and need for care. This also appeared to emulate Hannah taking on the role of both the victim through her vulnerability and the perpetrator through the controlling nature of her role.

Hannah also demonstrated repetitive and unsophisticated dressing and undressing of dolls in her play and made derogatory references to the dolls being 'naked' and not 'deserving'

clothes on multiple occasions, which again could serve both processing and communicative functions. The cognitive demands required to process the trauma may have impacted on her development and could account for her reduced non-verbal and imaginative play skills. Her use of punitive language when playing with dolls could also indicate that she has been exposed to negative expressed emotion, which may also account for the poor self-esteem she demonstrated. These observations may fit with the developmental trauma disorder proposed by Van der Kolk (2005) where chronic interpersonal trauma serves as the primary stressor and results in dysregulation and functional impairment across emotional, social and cognitive domains triggered by traumatic memories. This results in persistently altered attributions and expectation of others and of self.

1.6.3 Interaction between sexual abuse and atypical autism

Hannah's atypical autism does not account for her sexual behaviour, however it might have played a role in maintaining her behaviour, what she says (parroting adult wording and repeating phrases) and her overall presentation. The gross motor movements that Hannah demonstrated for example appeared to mimic sexualised dancing, but also seemed to have a sensory-repetitive function for her, which could be exacerbated by her atypical autism. Hannah also demonstrated poor understanding of social interactions and relationships and was controlling in her play, which are features of atypical autism. Children with ASD tend to experience difficulties making friends due to these features, which may explain Hannah's frequent references to her 'boyfriend' and her constantly pretending to call him. It is likely that if she has been abused, her abusers may have described themselves to Hannah as her 'boyfriend' and she may have come to regard them in this way. This may serve to fill the loneliness she may have experienced from not having same age friends and may have served as a vulnerability factor for her being subject to sexual abuse.

1.6.4 Confusion of attachment and sexual systems development

Patterns of development are seen in attachment, play and sexual development from infancy through to adulthood. In the early years the development of the innate behavioural attachment system and the sexual system proceed rather independently, becoming closely linked in adult romantic relationships (Shaver, Hazan & Bradsaw, 1988). Sexual abuse occurring at a formative time in the development of the attachment system can however cause fusion between the attachment and sexual systems (Diamond, Blatt & Lichtenberg,

2007), especially if the perpetrator plays a caregiving role. This may result in activation of both systems in the face of threat which can result in sexual behaviour and sexual intimacy being sought in the face of environmental threat, when what the child really requires is proximity to an attachment figure (Rich, 2006). These elements were observed in Hannah's behavior, further complicated by her atypical autism, which desensitises her to the conventions of normal social interaction and impairs her self-knowledge of emotion.

1.7 Reflections: differentiating ASD and attachment

Throughout the assessment I found it difficult to distinguish whether Hannah's behaviour was a manifestation of her atypical autism or a consequence of her experiencing sexual abuse and care disruption. I employed the Coventry Grid (Moran, 2010) and the resulting reflections on working with LAC with similar backgrounds to Hannah to aid differentiation. Reflections on the way children with ASD or attachment difficulties used the therapeutic relationship differently were particularly helpful. For example, Moran (2010) cites that while it requires greater effort to engage children with ASD and they may display elements of rigidity and control in the way they relate, they do not tend to test out emotional boundaries, making it easier to maintain them and that the relationship has a 'matter of fact feel'. Comparatively, Moran (2010) reflects that therapeutic relationships with children with attachment difficulties tend to have more of an 'emotional feel' and that the therapist has to work harder to maintain therapeutic boundaries.

Whilst working with Hannah I experienced elements of both for example, although it seemed that Hannah engaged quickly I felt I had to work hard to engage her and keep her engaged. There was also a strong element of Hannah attempting to control our interactions, at times a strong emotional feel to the therapeutic relationship and it was difficult to maintain appropriate therapeutic boundaries. For example, after making a disclosure of sexual abuse and then retracting it Hannah held my hand and told the other assessor that she loved her. There were also indications of Hannah splitting myself and the other assessor by directing derogatory comments at the other assessor and stating that she would only do as I asked. Throughout my work with Hannah I felt that her way of relating was inconsistent, as it would switch from having a 'matter of fact' to an 'emotional' feel. On reflection, I think this was a manifestation of the way her atypical autism interacted with her experiences of sexual abuse, particularly as her attachment system was activated by the disruption to her care and the process of the assessment.

1.8 Limitations

The limitations of the assessment are arguably attributable to the nature of the complex case involving abuse and the context of the child care assessment process for child care proceedings. For example, within the assessment there were elements of uncertainty as to whether the family was being completely truthful about Hannah's experiences. Additionally, formulating Hannah's presentation as being related to sexual abuse had to remain speculative due to the nature of the evidence attainable through the assessment process. The disruption to Hannah's care and the inconsistencies between different adult descriptions of Hannah also posed challenges to formulation. School and home observations may have proved helpful in further teasing this out. This however was not possible due to risk and safeguarding issues. The time frame for the assessment stipulated by the court also meant that other areas of assessment (i.e. of the family network) required prioritisation to aid formulation.

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1.10 Appendices

Appendix A: The questions for assessment from the letter of instruction

Number	Question
Q1.	Please describe Hannah's current health, development and functioning in accordance with each area of expertise within your clinical team and identify the nature of any significant changes, historical to present, which have occurred in respect to the following: • Behaviour including sexual, emotional and aggressive behavior • Attachment organization in respect of the principal adults that form or have formed part of Hannah's life • Social and peer relationships • Cognitive and educational development • Physical development, including non-organic physical problems (such as bedwetting and soiling), injuries and any pediatric condition.
Q2.	Please comment on the likely explanation for/aetiology of Hannah's presentation and behavior, in relation to her history and experiences, any genetic/innate/developmental difficulties and any pediatric/psychiatric disorders
Q3.	Please provide a prognosis and risk assessment of any identified difficulties if they are not addressed
Q.4	Please describe the Child's needs in respect to the above and in relation to the nature of care-giving and necessary treatment
Q.5	Please undertake an assessment of the mother's ability to: • Understand and accept the concerns that led to court proceedings • Understand and accept Hannah's presentation in respect of her sexual, violent and aggressive behavior • Provide Hannah with long term care • Protect Hannah in the event that the cause of her behavior is found to be or likely to be non-organic • Work honestly and openly with professionals in the treatment of Hannah

Q.6	Please identify the risk factors, if any, within the maternal family that could affect Hannah's rehabilitation to her mother's care, including any possible co-dependency issues within the familial relationships and how they can be addressed.
Q.7	Please identify and address any other issues that you feel are relevant which has not been specifically raised in response to the above and which are relevant to Hannah's long term care and treatment.

Appendix B: 'Maudsley Model of Parenting Assessments' 5 stage processes

Stage	Description
1	The children and parents are independently thoroughly assessed (psychological interviews, cognitive assessment, developmental assessment, psychiatric interview, risk assessments, risk and parenting interviews).
2	The family are seen together and in sub-units. The team then observe the content and process of the interactions.
3	The team collects collateral information on the adults and children by interviewing school, foster carers and other professionals involved with the family. The wider system is also considered through professionals' meetings, reading relevant documentation and discussions with the wider family.
4	The emotional impact of meeting family members on members of the team is also taken into consideration which provides subtle but important information that is relevant to the impact of difficulties on the children.
5	Finally the team discuss the analysis, formulation and recommendations and the report is then prepared by the lead clinician.

Case study II:

Treatment of ruminative and contamination OCD using CBT

Supervised by: Dr Nicole Jones

Southwark Improving Access to Psychological Therapies Service

Case Study II: Contents

2.1 Introduction

This case study details the treatment of ruminative and contamination OCD in a 27 year old women using CBT. It highlights challenges encountered during treatment relating to the nature of the client's OCD, her underlying cognitions and how CBT techniques were employed to manage these.

2.1.1 OCD: diagnosis and prevalence

Obsessive-compulsive disorder (OCD) is an anxiety disorder characterised by recurrent obsessions and/or compulsions. The individual engages in obsessions or compulsions for over an hour a day that causes marked distress and significantly interferes with their daily functioning (American Psychiatric Association (APA), 2000). Obsessions are defined as intrusive, repetitive thoughts, images, impulses or urges. Obsessions are distressing and ego-dystonic and acknowledged as originating in the person's mind and as unreasonable or excessive (Veale, 2007). Compulsions are defined as purposeful, repetitive, overt or covert behaviours, which the individual feels compelled to perform in an effort to relieve obsessional distress or prevent a feared event. Compulsions are often accompanied by a desire to resist them (APA, 2000) and covert compulsions are generally considered more difficult to resist or monitor, as they are 'portable' and easier to perform.

OCD affects between 1% and 2.5% of the population (Torres et al., 2006; Karno, Golding, Sorenson & Burnam, 1988) with as many as 50% of OCD cases developing during childhood (Karno & Golding, 1991; Rasmussen & Eisen, 1990). OCD is considered a serious anxiety disorder and associated with higher rates of attempted suicide (Torres et al., 2006). OCD can become chronic and debilitating if untreated, with sufferers often experiencing significant impairment in multiple areas of functioning (Torres et al., 2006), resulting in a poorer quality of life (Olatunji et al., 2007).

2.1.2 Cognitive theory

CBT treatments for OCD originate from the cognitive model of OCD, proposed by Salkovskis (1985, 1989). It argues intrusive thoughts are a universal human experience. Rachman and de Silva (1978) and Salkovskis and Harrison (1984) evidenced this when they reported over 90% of a non-OCD population experienced intrusive thoughts similar in content to OCD suffers. OCD sufferer's tendency to appraise intrusive thoughts as an impending threat is argued to differentiate them from non-suffers. It is therefore the

meaning of an intrusion, which causes distress and the need to neutralise the threat through compulsive behaviours. Rachman (1997, 1998) for example, suggested appraisals that indicate the person is 'mad, bad, or dangerous' result in distress and the urge to neutralise. Common fears encountered in clinical practice supports this (e.g. the fear of going 'crazy' or anxiety never ending) (Veale, 2007).

2.1.3 Thought-action fusion (TAF)

TAF (Rachman, 1993) is a key cognitive process in OCD where intrusive thoughts/images become fused with reality. Likelihood TAF is the belief having a thought increases its likelihood of occurring, whereas Moral TAF is the belief thinking about an immoral action is equivalent to committing the act (Veale, 2007).

2.1.4 Responsibility

Salkovskis (1985) theorises the core appraisal driving OCD is overinflated responsibility for the occurrence of harm or its prevention. Responsibility is defined as 'the belief that one has power that is pivotal to bring about or prevent subjectively crucial negative outcomes. These outcomes may have consequences in the real world, and/or at a moral level' (Salkovskis et al., 1995). This is typically the belief that harm might occur to the self, a loved one or another vulnerable person through what the individual might do or fail to do.

2.1.5 Cognitive model

The cognitive model posits the individual's dysfunctional misinterpretations of responsibility for their intrusions are maintained through a number of vicious cycles (outlined in figure 1). Negative interpretations of intrusions and responsibility appraisals lead to increased anxiety and mood changes, increased attentional bias for intrusions and triggers, as well as mental and behavioural avoidance. These effects increase the accessibility and salience of the individuals harm concerns and serve to maintain intrusions and responsibility appraisals.

Intrusions and responsibility appraisals also result in individuals engaging in neutralising or safety seeking behaviours (SSB) in an attempt to reduce or prevent responsibility, distress and the likelihood of harm. Salkovskis (1985) argues that SSB perpetuate intrusions by reinforcing the idea that harm would have occurred if the SSB had not been

conducted. This belief is strengthened by the associated decrease in anxiety, feelings of relief and avoidance of the feared consequence termed 'rewarding non punishment' (Salkovskis, 1985). Ultimately this maintains OCD by preventing the evaluation of alternative appraisals.

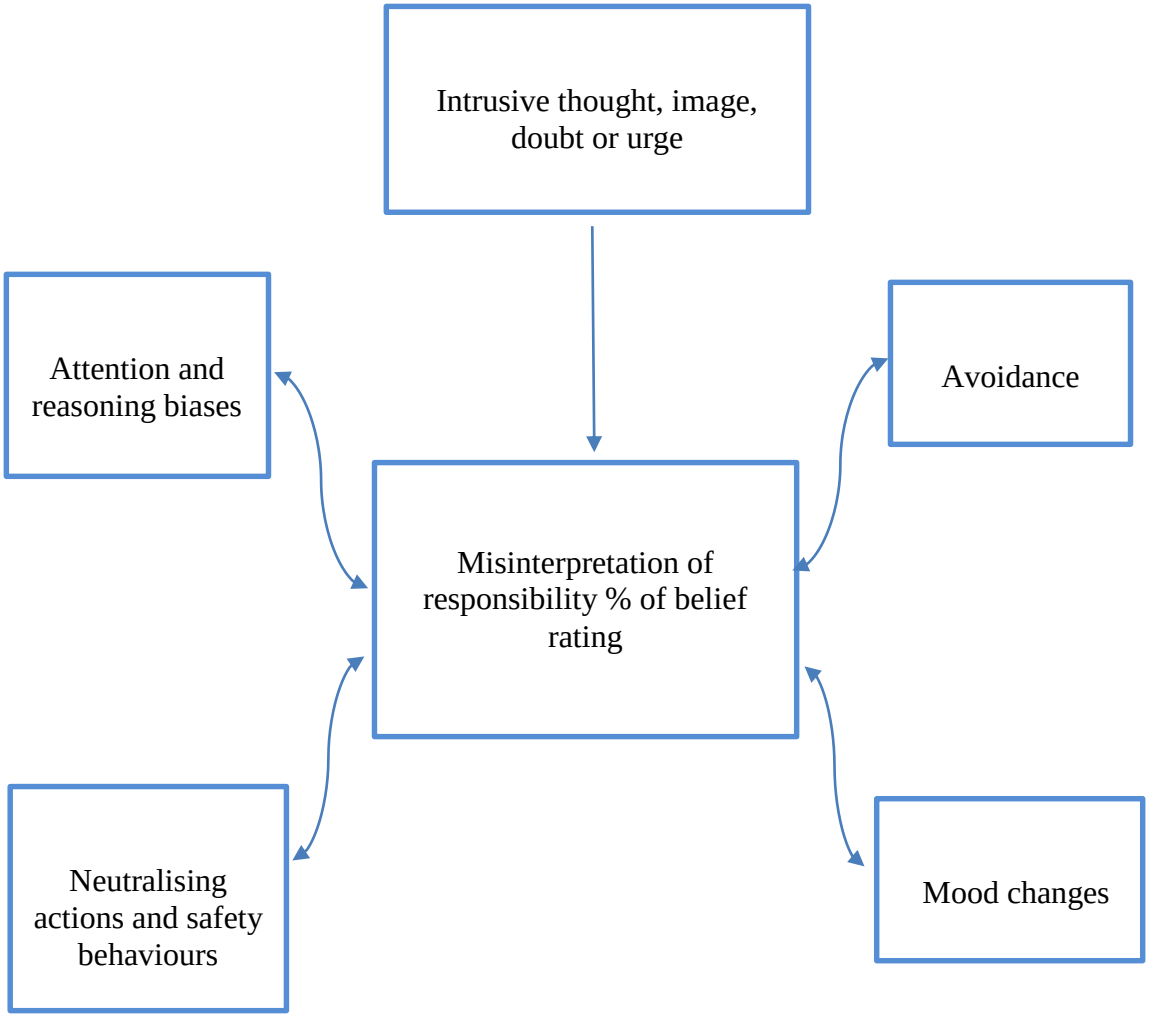

Figure 1: cognitive maintenance model of OCD

2.1.6 Emotion

Individuals with OCD often find it difficult to articulate their dominant emotion, which likely results from multiple mixed emotions (Veal, 2007). Although anxiety is usually the dominant emotion, co-morbid mood difficulties are often present such as anger, disgust, shame and guilt.

2.1.7 CBT interventions

CBT does not aim to prevent the client from experiencing intrusions. It aims to alter the client's relationship with their thoughts. It does this by helping clients understand why some strategies increase their symptoms and by developing and testing out alternative, less threatening interpretations of their intrusions. To facilitate this process an individualised formulation linking the client's presentation to the OCD model is developed collaboratively and referred to throughout treatment. The alternative interpretations are explored through Socratic questioning, normalisation, cognitive restructuring and Behavioral Experiments (BE).

2.2 Design

A standardized measure (The Obsessive Compulsive Inventory, OCI, Foa, Kozak, Salkovskis, Coles, & Amir, 1998) was administered at the beginning, middle and end of treatment to evaluate its effectiveness.

2.3 Referral

'Claire' a 27 year old, employed, White-British women was referred by her GP to IAPT (Improving Access to Psychological Therapies) for OCD assessment and treatment. The referral arose from concerns about Claire's continued use of anti-anxiety medication to manage her distress in response to 'horrific' intrusive imagery, despite its limited effectiveness. Claire was prescribed medication aged 18 after a panic attack triggered by such imagery. Claire had remained on medication due to fears she would experience further panic attacks which would not end and that this would increase the frequency and intensity of her intrusive imagery. Claire expressed a desire to engage in CBT with the longer-term goal of being able to come off medication.

2.4 Assessment

Claire attended a face-to-face assessment to gain a better understanding of how her OCD symptoms developed, currently presented and what was likely to be maintaining them in order to aid formulation and treatment planning.

2.5 Formulation

Claire experienced significant difficulty verbalising the nature of her intrusions, which resulted from her strong belief in moral and likelihood TAF. This was compounded by guilt, shame and embarrassment, which she experienced due to the nature of her intrusive images. Consequently three sessions were required to formulate and aid engagement. This led to three CBT formulations, which were developed collaboratively with Claire and referred to throughout treatment.

2.5.1 Horrific Imagery

With encouragement and normalisation Claire was able to label her intrusive imagery as falling under two categories: imagery of harm coming to her and others and sexual imagery. A CBT formulation of her OCD symptoms for images of harm was developed (figure 2). A common image Claire experienced was of a family member with a body part missing. Claire's appraisals of these images included: 'the image may come true'; 'I want it to come true'; 'I am dangerous and may cause harm to others'; 'I am responsible for the image and need to prevent it from happening'. Claire rated her belief in these interpretations at 70%. Her belief in these appraisals was increased by her worry that mounting anxiety may force her to 'go crazy' and enact the image.

In an attempt to reduce her distress, responsibility and the likelihood of the image coming true Claire felt she had to engage in a number of safety seeking behaviours (SSB) (figure 2). For example Claire would need to repeat the image a certain number of times or until it 'felt right', neutralise the image by replacing the 'dangerous' part with a rose (e.g. a knife) or decrease the severity of the images (e.g chop her mother's arm off instead off her head). Claire would also avoid any news or imagery of 'bad or gruesome' things, as

she believed this would make her more susceptible to experiencing horrific imagery and enacting it and was always on the lookout for these triggers in her environment.

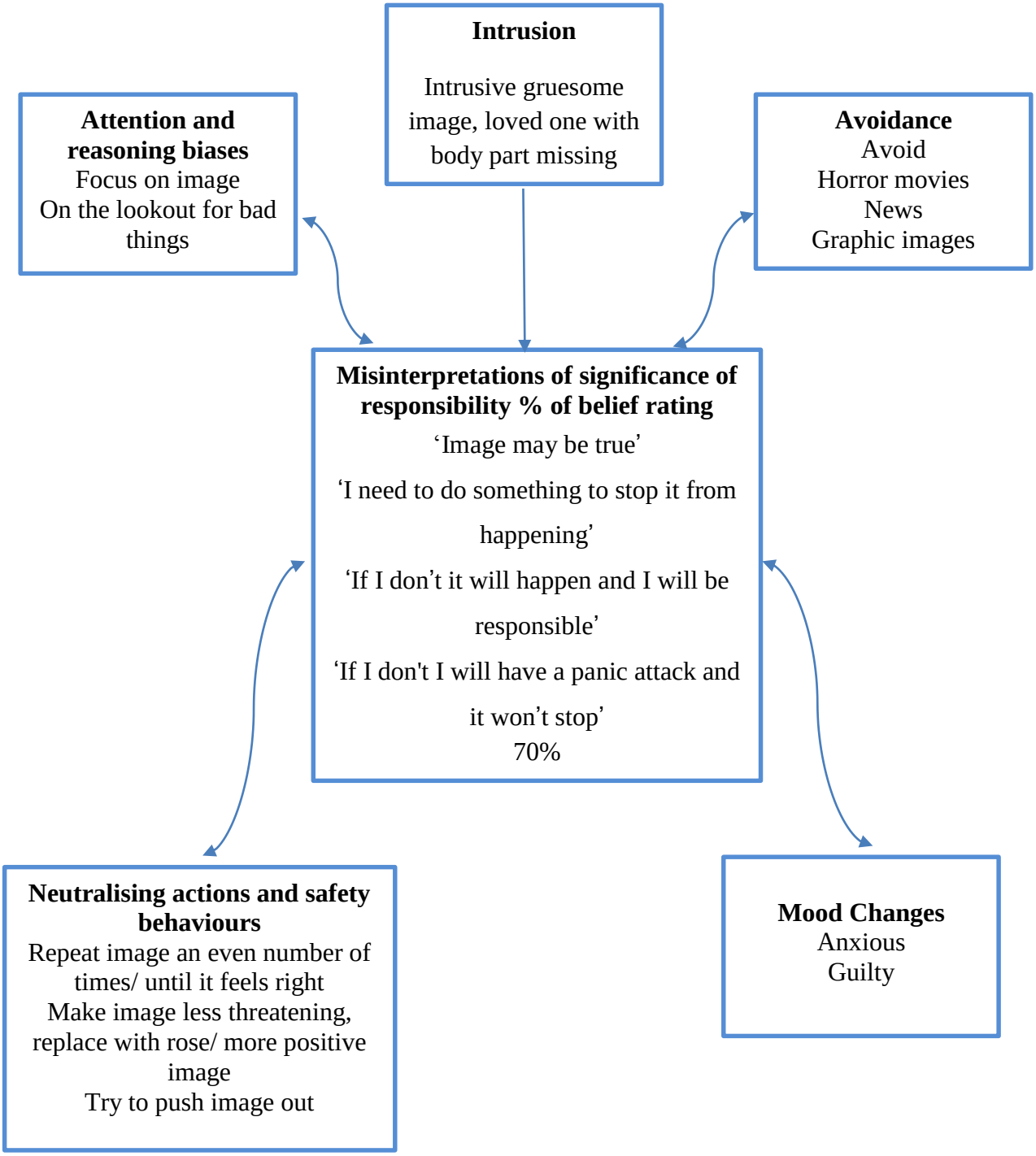

Figure 2: Formulation of 'horrific intrusive imagery'

2.5.2 Sexual imagery

Claire's sexual imagery was not explored until the therapeutic alliance was established and Claire had experienced some success in resisting her OCD through BE's. Claire reported she experienced imagery that involved sexual acts with family members, which she found repulsive and felt shameful about. This was linked into her longitudinal formulation and past experience of familial sexual abuse and treated in the same way as the 'horrific' imagery.

2.5.3 Contamination

Claire reported she had experienced contamination concerns and compulsive washing since 10 years old. This was also explored through formulation (figure 3) which confirmed Claire engaged in compulsive washing to prevent her from becoming contaminated, contaminating others and causing harm by making them ill, which she would be responsible for and believed 50%.

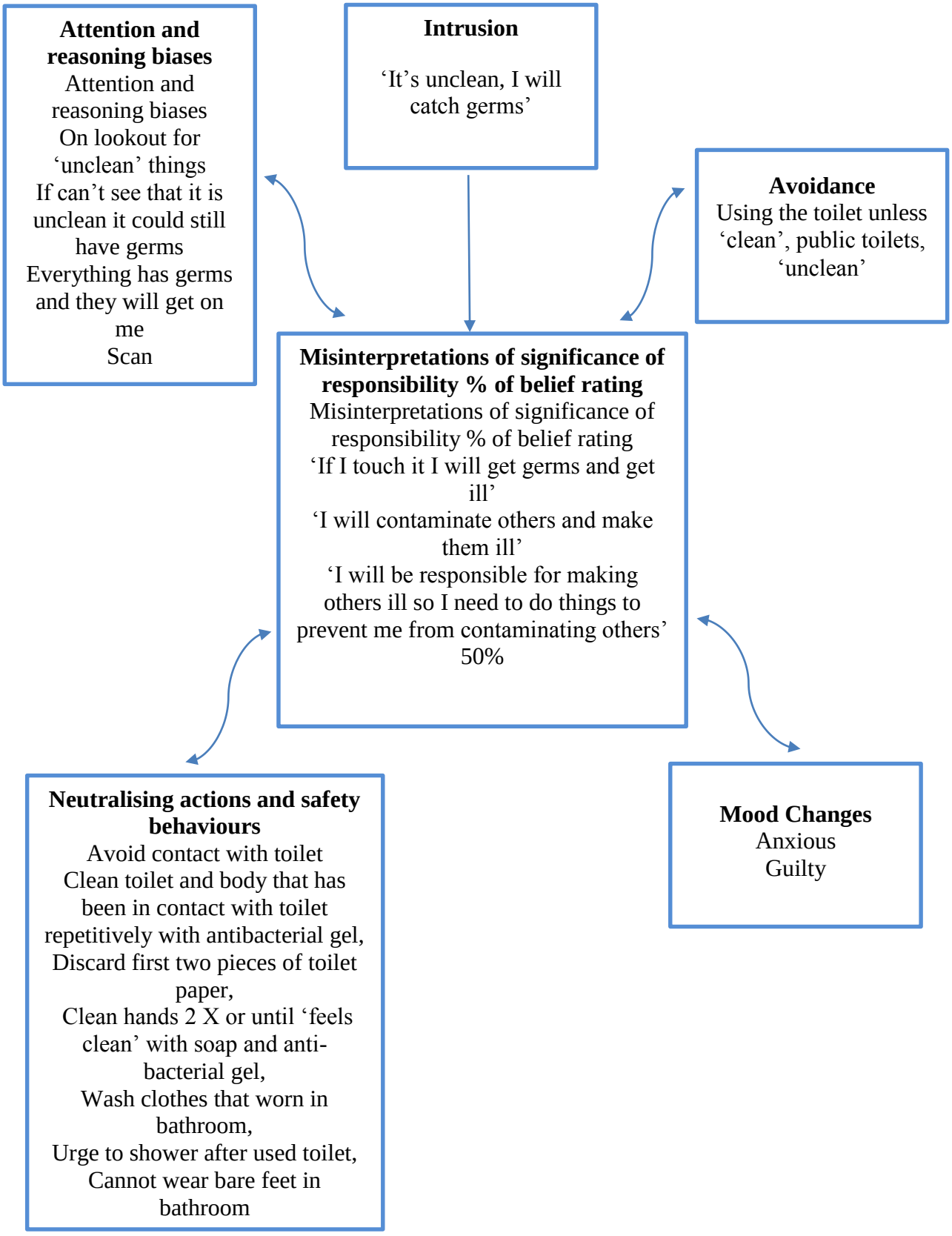

Figure 3: Formulation of contamination fears

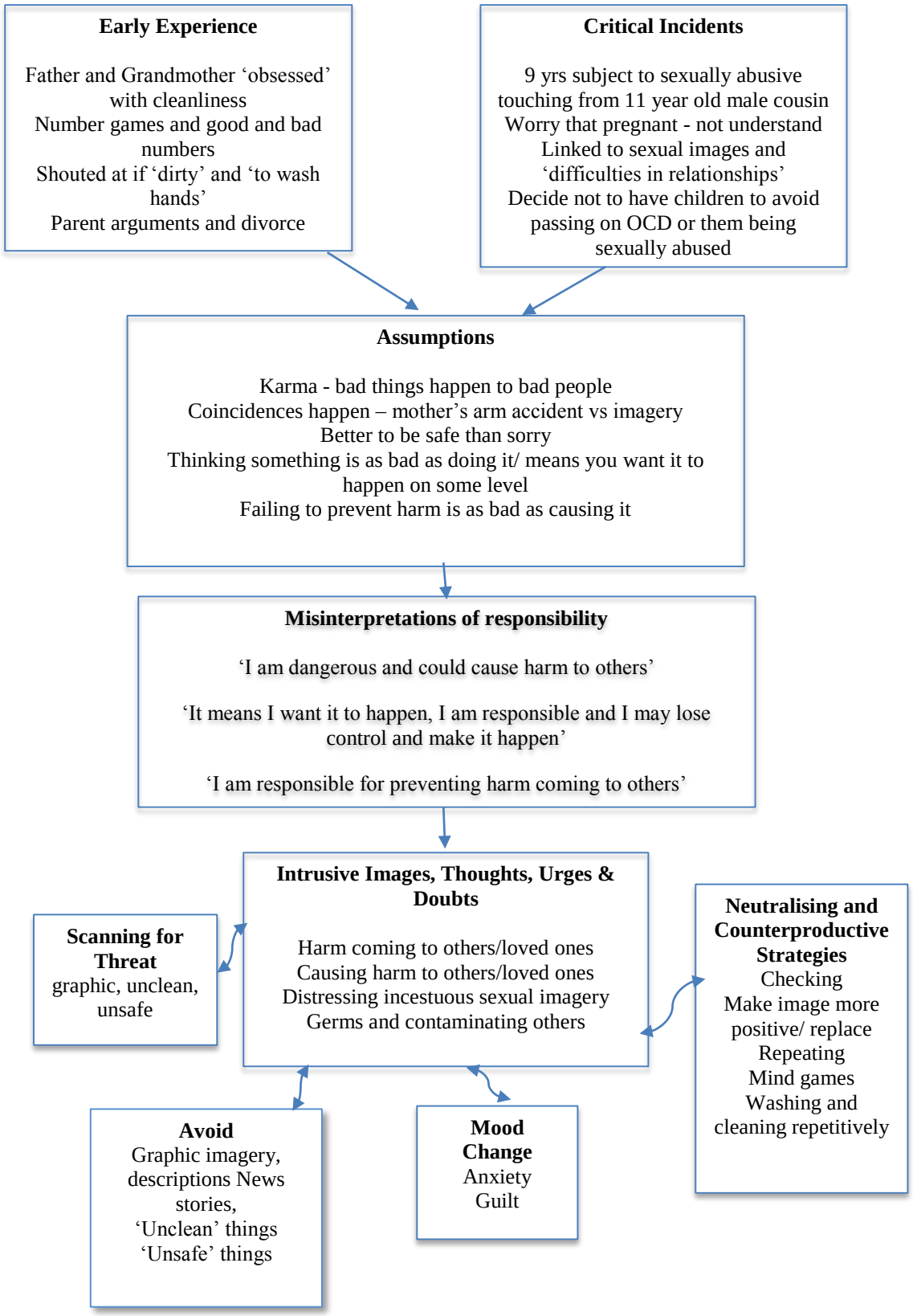

Figure 4: Generalised longitudinal formulation

2.5.4 Generalised longitudinal formulation

Cognitive theory posits the particular content of intrusions and appraisals relate to idiosyncratic assumptions or beliefs shaped by early experiences, which may become more salient following stressful life events. As it was clear Claire's OCD had multiple and shifting manifestations, including intrusive images, urges and doubts which led to compulsive neutralising, checking and washing a longitudinal formulation (Beck, 1979) was developed with Claire to aid her understanding of her OCD (figure 4). This helped Claire identify which early experiences (e.g. her father being 'obsessed' with germs and cleanliness) and critical incidents (e.g. being subject to sexual abuse from her older cousin when they were children) may have made her more vulnerable to developing OCD. It also helped highlight key assumptions (e.g. belief in karma) that were likely to feed into her intrusions and resultant misinterpretation of the significance of responsibility.

Importantly the longitudinal formulation supported Claire to generalize, so that she could see all of her separate obsessions and compulsions as part of the same OCD problem. This was particularly valuable for Claire as this understanding minimised her concerns about her OCD manifesting differently after treatment, by providing her with a structure to manage this.

2.6 Treatment

2.6.1 Normalisation

The CBT strategy employed to initiate the development of alternative, less threatening interpretations of intrusions is to normalise their occurrence and content whilst emphasising their irrelevance to further action (Veale, 2007). Claire was therefore presented with a list of intrusions drawn from a community sample and clinical examples. Claire had never disclosed the content of her intrusions before as she feared people would think there was something inherently wrong with her. Consequently, Claire had never learned that most people experience unwanted and distasteful intrusions at some point. As a result her belief that there was something inherently wrong with her she needed to control had not been disconfirmed. This had led to extreme avoidance of her OCD.

Socratic dialogue (Clark, 1998) was employed to discuss the similarities between intrusive thoughts of those with and without OCD. This led to the conclusion that the content of intrusive thoughts does not differ, but the degree of distress they cause, the effort invested to irradiate them and their duration does. This discussion helped Claire realise intrusive thoughts are part of the human condition and necessary for problem solving and creativity. Claire learned intrusions which conflict with a person's values causes them the most distress (e.g a priest experiencing blasphemous thoughts). This helped Claire realise that her distress indicated she did not want to act on the intrusions.

The discussion also highlighted Claire's interpretations of her intrusions, combined with her strategies to control them, was maintaining the problem. The observation that individuals who do not interpret or respond to their intrusions do not have OCD reiterated this. A BE testing out the effectiveness of thought suppression (e.g. trying not to think of a white rabbit) demonstrated the 'rebound effect' (actively suppressing thoughts increases their accessibility and frequency) to Claire and the likely role this played in maintaining her OCD.

2.6.2 Anxiety psycho-education

Claire held the belief her anxiety would increase if she did not engage in a compulsion to bring it down. She feared this could cause her to lose control, 'go crazy' and enact her intrusive imagery by harming someone. To reduce this belief so that Claire would be able to tolerate anxiety during BE's I provided Claire with psycho-education about anxiety (i.e. the 'fight or flight' mechanism, physiological effects and the habituation curve). Claire monitored her anxiety levels using the habituation curve to evidence that her anxiety always reduced. This was an extremely useful strategy as it provided Claire with enough confidence to engage in anxiety provoking BE's throughout treatment.

2.6.3 'Theory A, Theory B'

To assist engagement and a shared rationale, two competing theories explaining her OCD were set up to test out, a method termed "Theory A, Theory B" (Salkovskis & Kirk, 1997, Clark et al, 1998). This contrasts the client's current appraisal of intrusions 'Theory A' that she has a danger problem (as she is responsible for harm to others) with 'Theory B', which demonstrates the therapists' perspective that it is a worry problem (as she worries about causing harm to others). Claire was supported to evaluate the evidence supporting each theory (figure 5). This process helped Claire to see how she was living her life as if 'Theory A' was true and reported she believed this 70%. I explained that I believed 'Theory B' was 100% true and that as only one could be, treatment would involve gathering evidence and evaluating which theory is best supported (e,g. Theory B).

Table 1: ‘Theory A’ Vs ‘Theory B’

Theory A: Danger problem ‘I am a danger to others therefore I am responsible for harm coming to them and need to do everything I can to prevent it from happening’ 70%	**Theory B:** Worry problem ‘Because I am a caring person I worry about causing harm to others’ 30%
Evidence: I experience images/thoughts of harm coming to others and myself causing harm to others	**Evidence:** Thoughts/images are uncontrollable, everybody has them and they are undetectable by others Thoughts/images are just that, they are not real or important When I experience horrific thoughts and images I find them repulsive and they do not fit with me as a person I have never done anything to cause harm to someone Other people consider me unable to cause harm to others I am a ‘Hippy and love peace and animals’ I am a vegetarian as I don’t want to cause harm to animals I am a bit of a worrier, particularly about things that are important to me such as relationships and my work I am conscientious

What I have to do: Look out for and avoid things that might trigger images/ thoughts of harm, particularly graphic imagery or details of violence i.e.: News, TV programmes, books Try to push these thoughts out and replace them with less bad thoughts or with positive ones and repeat the action or thought/image until it feels right or a certain number of times Shower when feel the urge, look for and avoid unclean areas, wash my hands until they feel clean, wash myself whenever I come into contact with 'unclean' things, cannot walk barefoot on the bathroom floor **Stops me:** Relaxing Seeing films with friends Reading books Watching the news From doing day to day things without obsessing and doing rituals	**What I have to do:** Drop all of my safety behaviours (rituals) Spend more time doing things that are enjoyable and more time relaxing Spend more time focusing on things that are important to me like my career
Future: Obsessions and rituals will take up lots of my time and stop me from focusing on other things like my career Have to keep on doing my rituals to prevent harm from coming to others and will be ruled over by my images and thoughts I will not have children as I don't want to 'pass on OCD'	**Future:** I will be more focused and will be able to concentrate on things that are important to me I would consider moving and living abroad I would consider having children
Person: Anxious person that has to do things to prevent harm from coming to others all the time, leaving little space for me to do anything else	**Person:** Relaxed day to day but ambitious with long term goals which I would be working towards

2.6.4 'SMART' goals

Claire's short-term goal was dropping her SSB, her medium term goal was learning how to tolerate and not respond to her intrusions and her long-term goal was coming off anti-anxiety medication.

2.6.5 Safety seeking behaviours (SSB)

The role of SSB in maintaining her OCD was introduced using the builder's apprentice metaphor (Stott, 2001) where holding up a drying brick wall to stop it from falling down symbolised the using SSB, taking her hands off the wall symbolised dropping SSB and pushing the wall represented BE (see figure 5.).

2.6.5 Behavioural experiments (BE)

BE are planned experiential activities undertaken by the client to obtain new information to test their existing beliefs or new more adaptive beliefs (Bennet-Levy et al, 2004). Claire was introduced to three possible ways she could choose to respond to her OCD (Challacombe, Bream-Oldfield & Salkovskis, 2011) (figure 6).

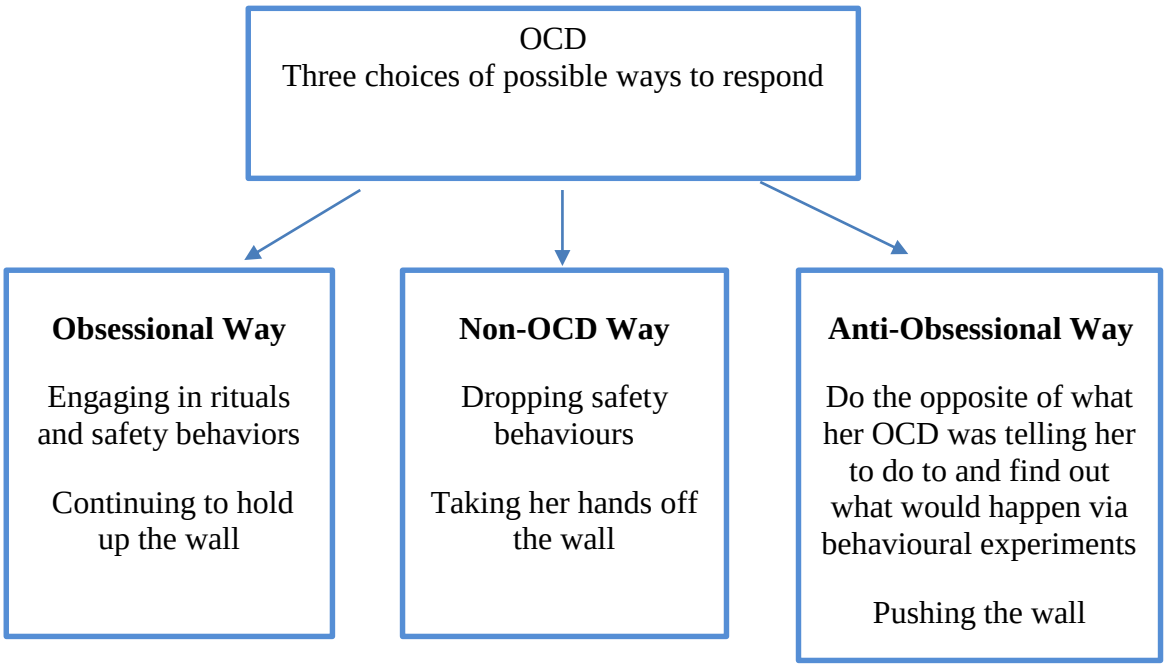

Figure 5: Three choices of how to respond to OCD

Detailed discussion focusing on assumptions involved in her appraisals of intrusions was required to identify key cognitions to test out via BE. This led to a modification of Rachman et al.'s (1996) experiment in which clients are asked to write down a sentence wishing harm on a loved one to explore the influence of likelihood TAF. After I modeled this to Claire, Claire wrote 'I hope Granny dies horrifically by 12:00 pm tonight'. Claire reported she believed this would happen 70% and managed not to engage in any SSB. The BE was evaluated using the factors displayed in figure 7. The outcome that nothing happened helped Claire conclude thoughts are just thoughts and do not have the power to make something happen and do not require further action.

Table 2: Completed BE record sheet for likelihood TAF

Target Cognition	***Belief %***	***Experiment***	***Predictions***	***Outcomes***	***What I learned***	***Belief %***
If I think something bad it will happen	80	Write a bad thought on the board - make it specific and drop safety behaviours and tolerate safety behaviours	My anxiety will stay very high and I will not be able to think about anything else until I know my Granny is safe It will happen and I will be responsible	was anxious for a bit and wanted to come back and wipe it off but I could manage my anxiety and it came down and I forgot about it Nothing happened	That thinking something bad does not mean it will happen and that I can manage my anxiety without doing safety behaviours and it will come down	20

After this BE Claire explained her belief in likelihood TAF had not shifted to 0% because there was always the possibility of 'coincidences'. On further exploration Claire reported she had experienced an image of her mother being decapitated and to neutralise this she chopped off her mother's arm in the image. Claire reported shortly after this her mother sustained a serious injury to her arm after a bowl fell out of a cupboard. Claire believed she had caused the accident through neutralising the image and felt guilty. To evaluate

this appraisal we drew out a ‘responsibility pie’ (figure 6) and attributed the percentage each possible factor was likely to have contributed to the accident. This analysis highlighted to Claire that there were so many contributing factors that her neutralising actions could not have played a role in the accident.

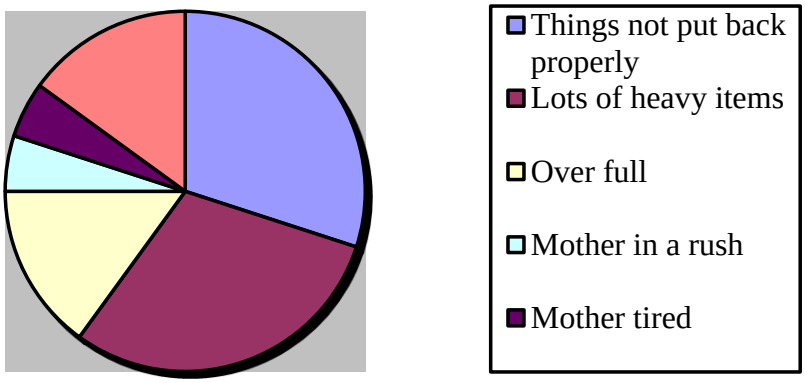

Figure 6: Responsibility pie of Claire’s neutralising image being responsible for her Mother’s arm being seriously injured VS an accident

2.6.6 Rumination OCD

To treat her rumination OCD Claire was encouraged to use mindfulness-based techniques to decenter from her intrusions and to see them as just thoughts/images, irrelevant to further action. Claire was taught to employ mindful imagery to observe and tolerate her intrusions by conceptualising the intrusive imagery as ‘mental driftwood’ in a stream, entering her mind and drifting along until they fell over a waterfall and out of her mind. BE’s where Claire purposefully induced horrific/sexual imagery whilst not responding to them were conducted to test out her belief in TAF and her ability to tolerate the images and resultant anxiety. Surveys exploring the types of sexual and gruesome imagery people experience and the impact they have on them were conducted. This served to normalise the frequency and content of Claire’s imagery and reduced her shame. This opened up discussion and helped shift her belief that she was a dangerous person.

2.6.7 Contamination OCD

BE's testing out the belief that she would contract germs, contaminate others and would be responsible for making them ill were employed in and outside of sessions to treat Claire's contamination OCD. This included touching 'unclean' toilet areas and eating without washing her hands. The outcome that no one became ill reduced her contamination belief from 50% to 10% and gave her confidence to drop all her SSB and complete contamination BE's independently whilst attending festivals.

2.6.8 Relapse prevention

A relapse prevention plan was developed with Claire including a description of the factors that had maintained her OCD, the techniques she had found most useful, potential triggers for setbacks as well as ways of resolving them. This focused on generalizing Claire's OCD and helping her to see it all as one big problem via her generalised formulation.

2.7 Measures

The OCI (Foa, Kozak, Salkovskis, Coles, & Amir, 1998) is a 42-item measure of severity of OCD symptoms with six subscale scores: washing, checking, ordering, obsessing, hoarding and neutralsing. Claire was asked to rate the frequency and extent of distress caused by circumstances on a scale of 0 (not at all) to 4 (extremely), giving a range of 0-168 for both severity and frequency ratings. Scores of ≥40 for caseness have been found to have 80% sensitivity and 80% specificity for OCD compared to a structured clinical interview. The authors found this measure to be valid and to have good reliability in people with OCD (Cronbach's $\alpha = 0.92$).

Table 3: Claire's OCI scores for frequency and distress over treatment sessions

	Baseline: 1st session	Mid: 7th session	Mid: 12th session	End: 16th session
OCI Frequency	64	72	72	84
OCI Distress	51	82	49	63

2.8 Evaluation of effectiveness

The OCI indicated Claire still met clinical caseness at end of treatment and there was an increase in the frequency and level of distress caused by her intrusions. This does not necessitate that the course of CBT was ineffective. To manage her OCD Claire had engaged in extreme avoidance since 10 years old. It is therefore likely that Claire's initial scores were not fully representative of the frequency or level of distress caused by her intrusions. Nor did Claire initially consider the majority of her intrusions or SSB as part of her OCD. Treatment however provided Claire with a different way of framing her problem and enabled her to confront her extreme avoidance. This is likely to have led to the increased frequency of intrusions in session seven. The realisation that her OCD had a wider impact on her life than she had considered is likely to have caused the accompanying increase in distress. By session twelve however Claire had engaged in a number of successful BE which had shifted her unhelpful beliefs and started to develop her confidence in 'Theory B', marked by a decline in her level of distress.

Claire's level of distress increased slightly in the last session, this was probably attributable to Claire's apprehension about the end of treatment and managing her OCD independently. The increased frequency may be attributable to Claire's more mindful awareness of her intrusions. Claire did however achieve all of her goals and noted a significant improvement in her quality of life. When evaluated by these standards the course of treatment was arguably effective. Claire successfully dropped all of her SSB, began to tolerate her anxiety and intrusions and was coming off her anti-anxiety medication at discharge. Claire also noticed a reduction in shame and guilt. In addition overcoming her contamination fears enabled her to take a promotion at work involving interaction with the general public and reported this had made her feel more positive about her future.

2.9 Limitations

Due to the entrenched and long lasting nature of Claire's OCD it is likely a period practicing CBT skills and building up evidence for 'Theory B' was required before Claire's OCD reduced below caseness and translated into reduced OCI scores. Within an overstretched IAPT service however, there was no provision for follow-up or booster sessions, despite Claire meeting the threshold of clinical significance at discharge. It is arguable Claire would have benefited from this further support which could have reduced the impact of any setbacks on her recovery and maintained her faith in the CBT model. The short term intervention and the various manifestations of Claire's OCD also meant the 16 sessions provided felt rushed, despite it exceeding the number of sessions usually prescribed by the service (12-14). For a less motivated client this may have been overwhelming.

2.10 Reflections

As Claire felt a huge degree of shame and guilt due to her strong belief in TAF and the violent and sexual nature of her intrusive imagery a slower pace was required in order to build up Claire's trust. This required a significant degree of normalising and modeling to encourage Claire to verbalise the nature of her imagery. Claire also found it difficult to express her dominant emotion as she experienced a range of emotions, resulting in her varied emotional presentation. This needed containment within sessions and reflection during supervision to ensure I remained focused on the presenting OCD problem and to safeguard against therapist drift.

Once a strong therapeutic alliance was established Claire was able to disclose sexual abuse and the nature of her images. This indicated Claire had been able to invest her trust in me as a therapist and in the CBT model and enabled me to judge when to push Claire to engage in BE which she found distressing. The high level of affect Claire displayed during BE challenged me to ensure I was following the CBT model and not inadvertently providing reassurance. These experiences highlighted the importance of fidelity to the CBT model and the therapists' active involvement in BE to gain the clients trust and to demonstrate their own faith in the treatment's effectiveness.

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Case study III:

Adapting CBT for anxiety in a 7-year-old boy with a diagnosis of Asperger's Syndrome

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Case Study III: Contents

3.1 Introduction

3.1.1 Asperger's syndrome and anxiety

Asperger's syndrome (AS) is a pervasive developmental disorder estimated to affect 0.087 % of children (Fombonne, 2005). AS is characterised by significant impairments in social communication and interaction, stereotyped behaviours, interests and activities, as well as motor-coordination problems (Gillberg, 1991). Related difficulties include sensory sensitivities (Rodgers & Ozonoff, 2005), executive functioning problems (Ozonoff, South, & Provencal, 2005), impaired empathy and theory of mind skills (Donoghue, Stallard & Kucua, 2010). The combined effects of these difficulties make children with AS vulnerable to developing mental health problems (Attwood, 2007). Research suggests approximately 65% of young people with AS have an affective disorder (Attwood, 2004) and anxiety is the most common, with prevalence rates ranging from 30% to 80% (de Bruin, Ferdinand, Meesters, de Niji, & Verheiji, 2007; Klin, Pauls, Schultz, & Volkmar, 2005).

3.1.2. CBT for anxiety with typically developing children

It has been questioned whether CBT is an appropriate treatment intervention for younger children, given their immature level of cognitive understanding. Doherr, Reynolds, Weatherly and Evans (2005) however found most 5-7 year olds tested were able to engage in tasks deemed necessary for participation in CBT (e.g. generating alternative explanations, identifying emotions, connecting thoughts and feelings) suggesting young children may be suitable candidates for CBT if developmentally appropriate modifications are made. Mounting evidence now supports this suggestion, although some children may require explicit support to develop prerequisite skills for CBT (Choate-Summers et al., 2008).

When developmental considerations have been accommodated then CBT has been recognised as an effective intervention for anxiety in typically developing children, across a number of studies and age groups (e.g. Albano & Kendall, 2002; Compton et al., 2004)

and systematic reviews support this (Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004; James, Soeler, & Weatherall, 2005).

3.1.3 Is CBT a suitable treatment for children with ASD?

Suggestions have been made that children with Autism Spectrum Disorders (ASD) or AS are not suitable candidates for CBT because they may lack the necessary cognitive and verbal skills required for CBT. This may account for the limited research in this area. For example, the emphasis CBT places on increased emotional awareness, recognition, management and problem solving may pose difficulties for children with AS. In particular, impaired theory of mind, which results in difficulties identifying emotions and cognitions in self and others (Baron-Cohen, 2001), may result in problems with meta-cognitive processes and in understanding different ways of thinking about events, which is argued to underlie CBT. What is questionable however, is whether such skills should be viewed as prerequisites for CBT, or skills which could be developed through CBT (Scapra, Williams-White & Attwood, 2013). In addition behavioural techniques are effective in children with developmental difficulties (Lord et al., 2005) and some argue it is unclear as to whether an additional cognitive element is required (Donoghue, Stallard & Kucua, 2010).

3.1.4. CBT for Anxiety with Children who have a Diagnosis of AS

Little research has looked specifically at CBT for anxiety with children who have a diagnosis of AS. The limited existing research however suggests that if CBT is appropriately adapted for the needs conferred through AS, CBT can prove an effective treatment option (Donoghue, Stallard & Kucua, 2010; Storch et al., 2013). This is in line with the case made for adapting CBT for younger children.

Group CBT has also shown to be effective for treating children with AS or high functioning ASD for example, Wood et al. (2009) found children (aged 7-10) who were randomly allocated to 16 sessions of adapted CBT for ASD and anxiety showed significant treatment responses on child diagnostic outcomes and parent reports of child anxiety. Importantly, child anxiety measures did not show any change through

intervention. This is a common observation within ASD populations and is argued to reflect their impairments in emotional insight and rigid thinking and poses challenges for the validity and selection of measures evaluating treatment effectiveness (Scapra, Williams-White & Attwood, 2013).

3.1.5. Adapting CBT for AS

Scapra, Williams-White and Attwood (2013) argue necessary adaptations to CBT need to be made to accommodate the special needs of children with AS (e.g. more concrete and visual thought processes, lower attention span). These are listed in figure 1:

- Providing affective education and reinforcing the connection between physiological feelings, anxious thoughts and anxiety related behaviours for specific situations
- Emphasising behavioural aspects (e.g. reducing anxious avoidance) as many children with AS may still find it difficult to understand thoughts and feelings after adaptations are implemented (Lang et al., 2010)
- Employing concrete examples matched to cognitive abilities
- Using visual aids to support concrete learning style such as drawing (e.g. encouraging to draw the body and where they feel anxious (Wood et al., 2009) and employing cartoons to aid engagement (e.g. using thought bubbles to elicit thoughts) and make sessions more fun (White et al., 2010).
- Using play and creative strategies to teach CBT
- Incorporating special interests to overcome difficulties with social engagement and attention and to increase motivation and participation (Wood et al., 2009)
- Increasing parent involvement by providing parents with psycho-education about anxiety and AS and supporting their role as a co-therapist by training them to notice antecedents of anxiety related behaviours and how to change consequences to reduce avoidance and promote exposures, positive coping and self-help skills (Lang, 2010; White et al., 2010)
- Working collaboratively at the child's pace and increased review and repetition of material to compensate for executive functioning difficulties

Figure 1: suggested adaptations to CBT for children with ASD

Stallard (2005) has drawn on clinical experience to develop the acronym 'PRECISE' (figure 1) to summaries the core features of CBT adapted to meet the cognitive needs of a child with AS and emphasises the importance of the therapeutic relationship underlying this.

Figure 2: PRECISE

3.2. Aim

The case study aims to review the effectiveness of a short course of adapted CBT for anxiety with a 7-year-old boy who had a diagnosis of Asperger's Syndrome. It also aims to highlight how CBT was adapted to account for his young age and diagnosis.

3.3. Case description

Jack was a 7-year-old boy with a diagnosis of AS who was referred to a tertiary Child and Adolescent Mental Health (CAHMS) Neurodevelopmental Team for support around anxiety. Jack's parents worked in education and Jack had two brothers aged 9 and 5.

3.3.1 Initial assessment

At assessment Jack was experiencing anxiety which presented in a number of ways including nightmares, fear of the dark, worrying (about his parent's whereabouts and school), compulsive checking behaviours (taps) and tic behaviours (throat clearing, facial twitching). It was also reported Jack found skills such as listening, organising and sustaining attention on some types of information difficult.

Identified triggers for Jack's anxiety included uncertainty, overestimating the chance of something bad happening and stress within the environment, as well as parental responses to his anxiety. Jack's experience of school appeared to play a maintaining role in his overall anxiety and it was noted Jack was preoccupied with wanting to do well at school and to fit in. It was recognised these may pose a particular challenges for Jack due to his social communication difficulties. Jack was put on the waiting list to receive CBT for anxiety with supportive parental work and school liaison.

3.3.2 Review

I met Jack and his mother (Mrs X) three months after assessment to review difficulties and aid treatment planning. I learned Jack had successfully transitioned to a new school where he had made friends and joined after school clubs, which had helped increase his confidence. I heard Mrs X had observed a significant reduction in Jack's anxiety since moving schools and that Jack had not displayed any checking or tic behaviours since the transition. Mrs X attributed this to the new school's sensitive management of Jack's difficulties.

Mrs X reported Jack's 'meltdowns' were the most concerning remaining difficulty the family wanted support managing. 'Meltdown' was the family term given to Jack's behavioural outbursts when he became overwhelmed by anxiety/stress and anger and he would act aggressively. Mrs X reported that Jack had recently demonstrated his most severe 'meltdown' in response to her turning off his favourite cartoon before it had finished. Jack reportedly ran at his mother, repetitively pulled her clothes, punched her arm and tried to bite her.

I heard this was the first time Jack had demonstrated this level of behaviour and it had shocked his mother. Mrs X was able to reflect on how Jack's AS and need for certainty may have influenced his abrupt and extreme reaction to the change in routine. Jack was also able to verbalise what made him angry (not being able to watch loony tunes, which he always watches) how it made him feel (heartbroken, still very cross and butterflies in his tummy) and said that he 'attacked' his mum. Jack's ability to sequence the events and

label how it impacted on him physically, emotionally and behaviourally indicated that Jack was likely to be a good candidate for CBT.

3.3.3. Treatment plan

Although Jack's overall anxiety had reduced, it was agreed it would be beneficial for Jack to have 6 sessions of adapted CBT to help Jack develop coping strategies to manage future stress/anxiety and to reduce the occurrence of 'meltdowns'. Due to Mrs X's working constraints, Jack was seen individually at school. Mrs X attended sessions to help facilitate her understanding of Jack's anxiety in the context of his AS and how to practically implement CBT strategies to reduce 'meltdowns' and parental maintaining factors.

3.4 Intervention

CBT for anxiety is based on the premise that anxiety can be an appropriate, protective response to real danger but that individuals with anxiety disorders have an excessive, maladaptive response to situations that are not dangerous to them (Kendall, 1993). The maladaptive response constitutes anxious thoughts, feelings and behaviours, accompanied by physiological signs of arousal. CBT aims to target this maladaptive response by providing children with the coping strategies needed to change their distorted appraisals and reduce their physiological arousal to a level at which they are gradually able to face feared stimulus.

3.4.1. Formulating feeling anxious

The example of Jack's recent 'meltdown' was used to draw out the connection between the four symptoms of anxiety using the 'hot cross bun' formulation. Jack was encouraged to draw this out as a comic strip, demonstrating where he felt anxious in his body and using thought bubbles to aid his engagement. Jack provided concrete expressions of abstract experiences, which contained anxiety-laden meanings. For example, Jack reported feeling as if there was 'a knife through his heart and brain' when he had a meltdown and feeling 'dizzy' and 'as if he might stop breathing'. Jack also stated that

having a ‘meltdown’ made him feel as if he needed to ‘run around’ and made him think that he wanted to hurt someone and is losing control. After a ‘meltdown’ Jack reported that he felt ‘a bit calmer’, ‘sorry’ for his behaviour and ‘wanted to be alone’.

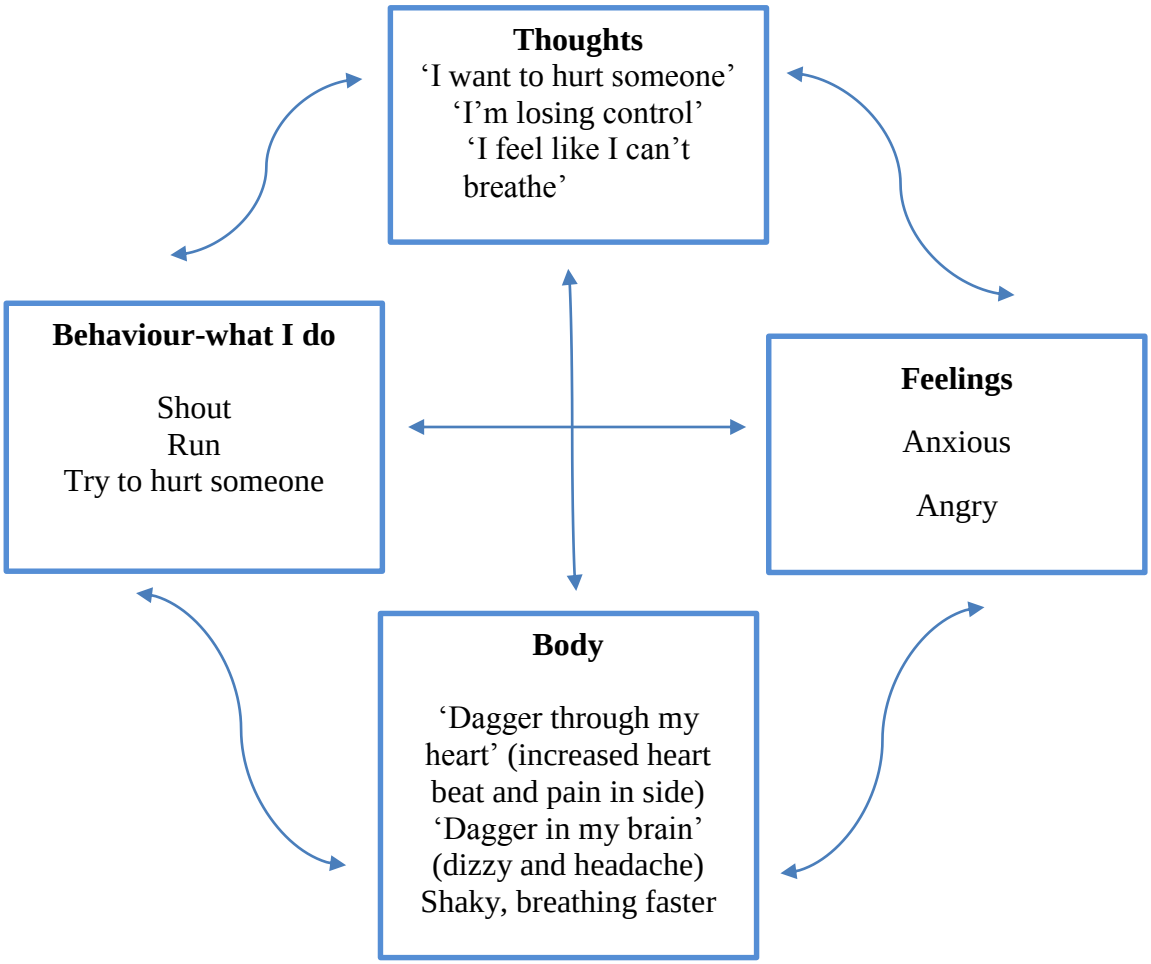

Figure 3: Formulating ‘meltdowns’

3.4.2 Psycho-education

I provided Jack with affective education around anxiety and familiarised him with the CBT model. I explained that anxiety is an uncomfortable feeling in our body that includes feeling stressed and worried, which comes with thoughts in our head and impacts on how we feel and what we do. The comic strip of Jack’s ‘meltdown’ revealed that he was experiencing physiological symptoms of anxiety but was interpreting them literally (i.e. ‘stabbing in the heart and brain’) which was likely to be contributing to his overall anxiety

and extreme reactions. I supported Jack to learn about anxiety by harnessing his special interest in animals and drawing skills and using a comic strip about the 'flight or fight response' using the caveman versus a saber-toothed tiger story.

3.4.3 The effects of anxiety on the body

We spent some time understanding the different effects anxiety can have on the body using diagrams to ensure Jack had a new and less frightening rationale for why he felt as if he was being 'stabbed' in the head and heart when he was stressed. I also provided the message that although anxiety feels unpleasant it cannot do anything to hurt us and has actually developed to keep us safe.

3.4.4. 'Emotionometer'

To help find out what antecedents triggered Jack to have a 'meltdown' we made an 'emotionometer' together: a 'thermometer' which can help children and those around them visually measure how high their stress levels are out of 10, 10 being the highest level of stress. To help with grading different levels of stress Jack used the metaphor of gradually turning into a St Bernard dog to indicate that he felt like he was losing control and was overwhelmed by stress. Jack independently suggested the idea of gradually turning into a dog to represent his increasing levels of anxiety as he recognised that he felt like he might hurt someone when he was overwhelmed with anxiety and understood that this was the same for dogs. This use of Jack's special interest in animals supported his engagement by aiding collaborative working and making the session fun. It also made the concept of graded levels of anxiety more concrete and easier for him to understand.

For Jack 1/10 stress felt like he was growing paws and 10/10 felt as if he had fully turned into a dog. Jack was supported at home to put different situations that triggered stress/anxiety on his 'emotionometer' and to indicate how anxious out of 10, and how much he felt as if he was turning into a dog. This indicated that the situations that made Jack feel stressed were related to his AS and included changes in routine, deviation from his agenda, uncertainty and sensory sensitivities.

3.4.5.'Emotional tool box'

Jack and I developed an 'Emotional Toolbox' of 8 different strategies Jack could use to help him calm down and 'turn back into Jack' once he noticed that he was becoming stressed and felt as if he was 'turning into a dog'. These were based on CBT strategies for managing anxiety and developed in collaboration with Jack, who named them and drew each one out to remind him what he needed to do when using each tool. These are included in box 2 and further detailed in the appendix.

1. The 02 Regulator (Diaphragmatic Breathing)
2. Imagining a Calm Scene (visualisation using his five senses)
3. Intensing (progressive muscle relaxation)
4. Stretch-a-size (stretching)
5. 'Burn-up-speed' (doing something active and energy burning because Jack reported feeling as if he needed to 'go fast' when he had a 'meltdown')
6. Artistic Flare (expression and distraction through drawing)
7. Chima Count (distraction, counting and naming his favourite video game characters)
8. Helpful Thought Missiles (thought challenging, identifying 'unhelpful enemy thoughts' and shooting them down with 'helpful thought missile')

Figure 4: 'Emotional tool box strategies'

We practiced using these tools in sessions and adults both at home and school were provided with detailed descriptions of these to help Jack notice when he was becoming anxious and encourage him to practice using them to manage his anxiety.

3.4.6 Sessions with Jack's Mother

It is recognised that parental anxiety and parenting style can contribute to the development of anxiety in children as anxious parents are more likely to have anxious children (Raphee, Schniering, & Hudson, 2009). Despite the complex and multiple influences on inter-generational anxiety transition, it is agreed that families are likely to play a role in

modeling to children what is accepted as anxiety provoking (Raphee, Schniering, & Hudson, 2009). During assessment it was identified that Jack's mother presented as quite anxious (preparing a list of problems so that she did not forget what she wanted to say, providing a lot of detail and asking for reassurance around 'typical development'). I therefore employed a more systemic approach by providing Mrs X with consultation around anxiety and how to implement Jack's strategies to help him manage his anxiety.

The likely factors maintaining Jack's anxiety, including the difficulties conferred by his AS, were explored with Mrs X. Drawing out the maintenance cycle of anxiety facilitated this. It was explained that avoiding stressful situations, seeking reassurance and checking behaviours reduced Jack's anxiety in the short term and were reinforced as a result. It was explained that these behaviours are unhelpful as they maintain anxiety in the longer term by preventing Jack from discovering that his feared consequences do not occur, anxiety is not dangerous and he can tolerate it. It was highlighted that these cycles would be maintained if the adults around Jack did not challenge these behaviours. The link between her own anxiety and complying with Jack's avoidance and reassurance seeking to reduce her own anxiety was highlighted. It was emphasised that the family and school should encourage Jack not to engage in these unhelpful behaviours and refrain from providing him with reassurance to help reduce Jack's anxiety in the long term and gradually support him to face the feelings of anxiety.

Mrs X agreed to use Jack's 'emotionometre' at home to continue to identify triggers for Jack's meltdowns and to grade his anxiety out of 10. Mrs X also agreed to encourage Jack to use his 'tools' to manage and tolerate his anxiety at home. This was shared with the school network to aid generalisation of these skills. The 'emotional toolbox' was depicted in a comic book made with Jack in sessions and his mother supported him to make a portable key ring version to use at school and in the community.

Towards the end of treatment Jack's mother reported Jack was experiencing new difficulties in friendships. I provided her with consultation on how to use social stories with Jack to help him understand social situations. For example, using tailored comic strips where Jack develops the art work and the adult supports the content of thought bubbles to help Jack understand what other people were likely to have thought and felt in the situation. I also put Jack on the waiting list for a social skills training group to support

the development of social skills in the future, as this was likely to be an ongoing difficulty for Jack due to his AS.

3.5 Assessment measures and limitations

The intervention was assessed in accordance with children and young people's IAPT (Improving Access to Psychological Therapies). As Jack was resistant to completing questionnaires even with support, parent versions were completed. Measures were administered at assessment, beginning and end of treatment.

3.5.1 Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a brief screening instrument used to assess positive and negative aspects of children's behaviour. Although the clinical usefulness of the SDQ has been confirmed in the field of child psychiatry it has not been specifically validated for children with ASD (Lizuka et al., 2010). Research indicates children with ASD tend to score significantly higher on emotional and peer problems sub-scales. As the DSM-IV diagnostic criteria for ASD are based on qualitative impairment in social interaction, which results in peer problems, this is not surprising. As the impairments in social interaction are pervasive, it is arguable that using the SDQ to evaluate treatment effectiveness in ASD is fundamentally flawed. Although the service recognises these limitations, the SDQ is used in order to meet the Trust's expectations of use of routine outcome measures.

From Mrs X's report, Jack's emotional symptom score reduced from a 'abnormal' to a 'borderline' level of difficulty from assessment to end of treatment. This may indicate that Jack was beginning to use some of his 'emotional tools' to help him better manage his anxiety. This was reflected in Mrs X's comments that Jack had been independently using his 'O2 regulator'/diaphragmatic breathing when he felt anxious. Interestingly Jack's total difficulties score increased, which may reflect more noticeable friendship difficulties at school, demonstrated by an increase in the peer problem score. This may indicate that although the course of treatment was helpful for providing Jack with anxiety management skills it did not aid his difficulties with social interaction. This could be because the treatment was not targeted at social skills or because this is part of his ASD, which is not amenable to change through short-term intervention. Alternatively, the increase in scores on this measure could indicate increased awareness and attention

towards this aspect, potentially in the context of overall reduced anxiety levels.

Table 1: Jack's scores as rated by his mother on the SDQ across the intervention

Scale	Initial Assessment		Beginning of Treatment		End of Treatment	
	Score	Classification	Score	Classification	Score	Classification
Total difficulties	19	Abnormal	20	Abnormal	23	Abnormal
Emotional symptom score	7	Abnormal	7	Abnormal	4	Borderline
Conduct problem score	2	Normal	4	Abnormal	4	Abnormal
Hyperactivity score	6	Normal	6	Normal	8	Abnormal
Peer problem score	4	Abnormal	3	Borderline	7	Abnormal
Prosocial score	8	Normal	5	Borderline	3	Abnormal
Impact score	4	Abnormal	4	Abnormal	5	Abnormal

3.5.2 The Revised Child Anxiety and Depression Scale Parent Version (RCADS-P)

The RCADS-P is a parent-report questionnaire of youth anxiety and depression with scales corresponding to the DSM diagnoses of anxiety disorders and depression. Although the RCADS-P has previously demonstrated strong psychometric properties in a clinic-referred sample (Ebesutani et al., 2010) it has not been validated with ASD populations.

Table 2: Jack's scores as rated by his mother on the RCAD-P across the intervention

Scale	Initial Assessment		Beginning of Treatment		End of Treatment	
	Score	Classification	Score	Classification	Score	Classification
Separation anxiety	12	Clinical	14	Clinical	13	Clinical
Generalized anxiety	10	Clinical	7	Borderline	12	Clinical
Panic	2	Unlikely	3	Unlikely	2	Unlikely
Social phobia	17	Clinical	16	Borderline	14	Borderline
Obsessions/ compulsions	8	Clinical	5	Unlikely	7	Clinical
Depression	11	Clinical	9	Borderline	8	Borderline
Total anxiety	49	Clinical	45	Clinical	48	Clinical
Total Anxiety and depression	60	Clinical	54	Clinical	56	Clinical

The RCADS-P indicates that overall there was little reduction in Jack's anxiety as reported by his mother, but a small improvement in his mood. Arguably maternal anxiety could have contributed to over reporting of Jack's anxious symptoms (Frick, Silverthgorn, & Evans, 1994), particularly due to Mrs X's worries and uncertainty about managing fallout from Jack's social difficulties with other children's parents at the end of treatment which could have led to an underestimation of change.

It appears that there is some inconsistency in the symptoms reported by Jack's mother on the two measures, which could be attributable to the validity of the measures. Research

indicates that there is a great need for further investigation into the applicability of traditional measures of anxiety and changes in target symptoms for children with ASD. Such research suggests until a consensus on 'best practice' measures within this population is established a healthy scepticism is called for with respect to the precision and validity (White, Oswald, Ollendick & Scahill, 2009). This may raise questions about the use of young person's IAPT measures to evaluate treatment interventions in children with ASD and the funding of services.

3.6 Discussion

The CBT Jack received was arguably well adapted to meet his needs conferred by his age and AS. These adaptations reflected those advised by Scapra, Williams-White and Attwood (2013) and Stallard (2005). For example, partnership working provided the foundations for the intervention as Jack was motivated to learn about and reduce his 'meltdowns'. Jack's impressive imagination, drawing skills and special interest in animals were used throughout sessions to aid engagement and to make the sessions more enjoyable and collaborative. For example, these elements were drawn upon to facilitate creative ways of making CBT principles concrete, visual and understandable. In particular it was clear that Jack benefited from CBT principles being presented through comic strips, an emotionometre, metaphor and his 'emotional tool box', as Jack remembered these aspects session to session. Jack's ability to summarise key points at the end of each session also demonstrated that the information provided was pitched at the right developmental level. Jack also benefited from affective education which served to promote empathy as Jack appeared to feel understood and as if he had been provided with a concrete explanation for his 'meltdowns'. This was particularly helpful for understanding his physical symptoms of anxiety as he had previously interpreted them literally, as 'stabbing pains', which was increasing his anxiety.

3.7. Limitations

There were however some recommended adaptations which were harder to fully adhere to. For example although the sessions aimed to encourage investigation and experimentation through charting triggers using his emotionometre and practicing skills from his 'emotional toolbox', irregular sessions with his mother due to her work commitments limited how supported this was at home early in treatment. Once this was recognised however telephone consultation sessions were added to support face to face sessions where Jack's mother was 'trained' as a 'co therapist'. For example Mrs X was supported to recognise antecedents of Jack's anxiety related behaviours and how to change consequences to reduce avoidance and promote exposures and positive coping through reinforcement (Lang 2010; White et al., 2010). Once implemented this was well received by Jack's mother who found this more containing as it provided her with a structured way of responding to Jack's challenging anxiety related behaviours. This could have been further improved by greater involvement of Jack's father to promote consistency. Jack's school however was provided with a detailed plan on how to support Jack to manage his anxiety to aid the generalisability of these coping skills. Although the sessions aimed to facilitate Jack's self-discovery this was only supported to a minimal degree. It is arguable that longer term support to implement his 'emotional tool box' will be required by the systems around him to develop this.

3.8 Reflections

I found creatively adapting CBT for Jack fun and felt this shared enjoyment of our sessions supported Jack's engagement. I also felt the use of humour, practical tasks and drawing upon his special interests were essential to maintaining this engagement as treatment progressed. The value of psycho-education for both Jack and his mother was clear and the importance of working with the system to support Jack to get the most out of CBT was highlighted in early sessions when his parents were less able to engage in appointments due to work commitments. The role of the school environment and their understanding of needs conferred by AS proved to be invaluable in reducing Jack's overall anxiety from the initial assessment to the start of treatment and emphasised the importance of involving school and the family network in the implementation of coping skills. Due to the improvement in Jack's anxiety prior to treatment I felt the intervention

was serving a preventative role by capitalising on gains to implement more effective coping strategies with the caveat that due to his AS, Jack may always experience some level of anxiety, but practicing his anxiety management strategies will increase his ability and confidence in coping with this anxiety. This led to further reflections around service delivery and how Jack reached tier three services with limited early intervention and ongoing support, despite evidence of ongoing need within this population.

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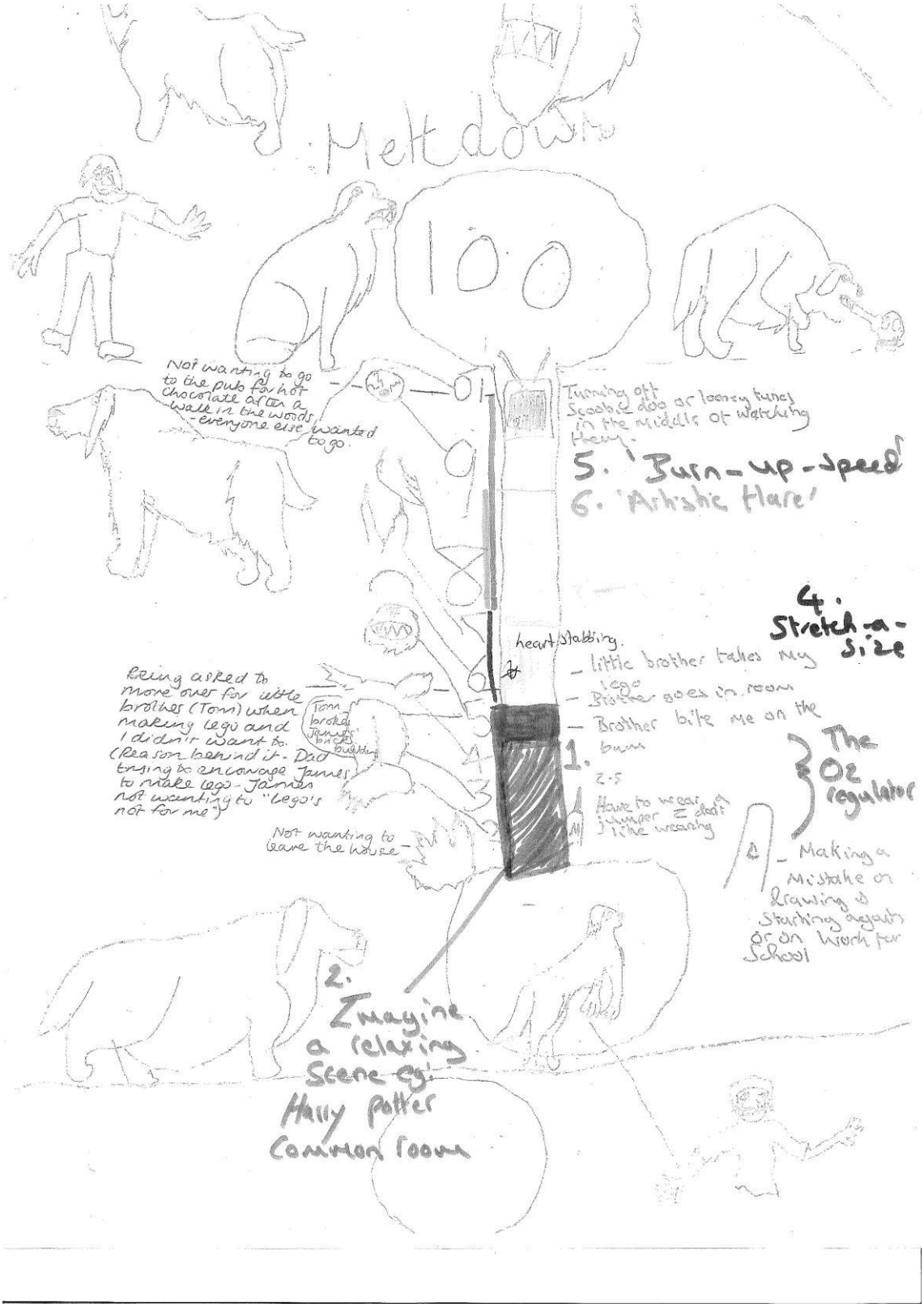
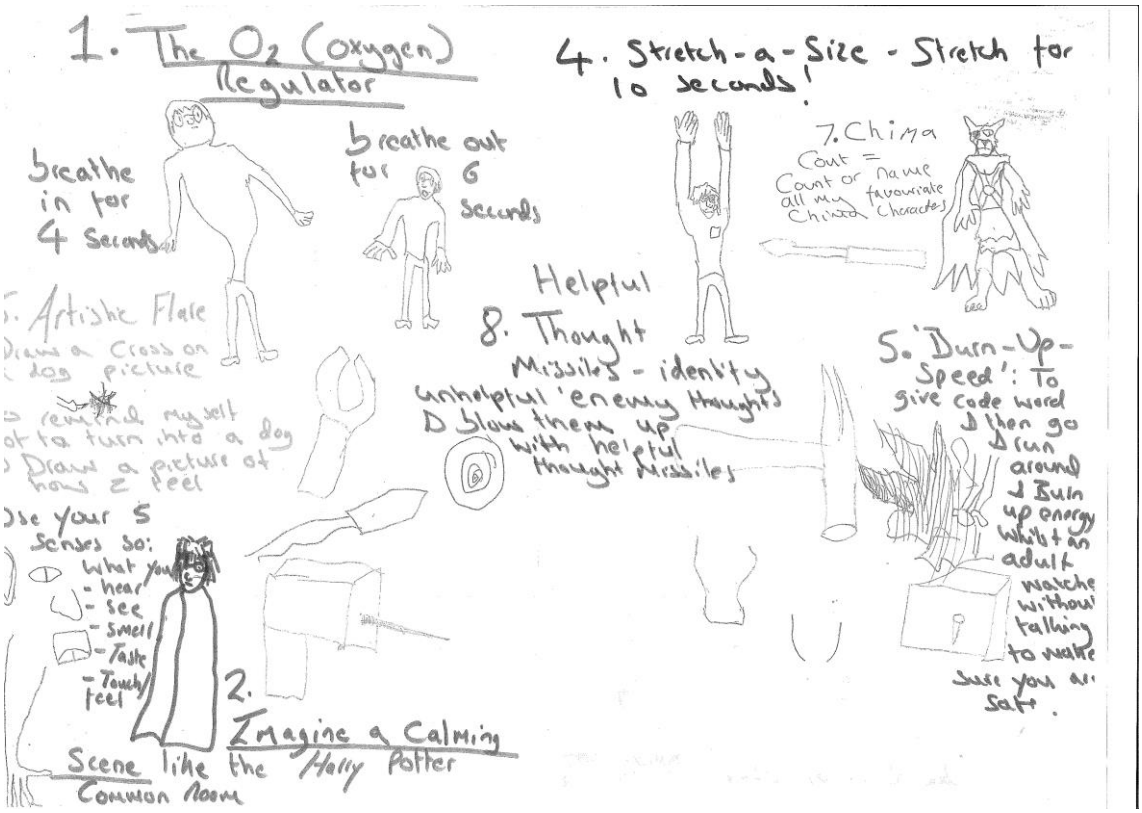
3.10 Appendices

Appendix A: Emotionometre



Appendix B: Anxiety management strategies

The 8 tools designed by Jack to help him manage his anxiety are detailed below so that adults at home and school can support Jack to use them when he notices that he is getting stressed, as if her is turning into a dog.



1. The 02 Regulator (Diaphragmatic Breathing)

This is where Jack breathes in for 3 seconds and then breathes out for 4-5 seconds. Jack can try and do this in a way that no-one notices what he is doing so that he can use it in class as well as at home. This gets more oxygen into the body and tells the brain that the body does not need to get ready to fight or run away and helps the brain tell anxiety to go away.

2. Imagining a Calm Scene

This is where Jack can use his brilliant imagination to imagine being in a relaxing place where he feels happy and calm. We said that for this to work really well, Jack would need to make the scene as real as possible. To help create this scene in his mind Jack can be prompted to think about his 5 senses, what he can hear, see, smell, taste and feel in his imagined place. Jack chose the Harry Potter common room as his calm place and when we practiced this he said he could hear and see other wizards talking and laughing. He said he could feel the big, comfy, soft sofa he was sitting on and could smell and taste lots of unusual things from eating magic beans like grass.

3. 'Intensing'

This is where Jack sits or lies down and tenses each different part of his body one at a time for 3 seconds and then relaxes it for 3 seconds. To do this Jack can be prompted to start at his toes and go all the way up to his forehead. Jack can be prompted to do this with his eyes opened or closed and can do it with calming music on if he wants. This is to help the body learn what it's like to be tense when it is stressed and how it is to feel relaxed. This can be done when Jack is stressed or when helping him to feel calmer after a stressful day.

4. Stretch-a-size

Jack said that stretching can sometimes make him feel a bit calmer because he can concentrate on the stretching instead of what has made him feel stressed. We called this tool stretch-a-size and by testing it out we found that Jack would need to stretch for 10 seconds to feel a bit more relaxed.

5. 'Burn-up-speed'

Jack said that when he feels like he is going to have a 'meltdown' he feels like he needs to run. We came up with a tool to help him burn up all of his stressie energy when he feels like he might have a meltdown. We said that if Jack felt like this he could say a code word to an adult like 'burn-up-speed' (to be agreed with adults) and then the adult would

know that Jack needed to run around outside or up and down the stairs until he had burnt up all of his stressie energy. We said that an adult would need to watch Jack to make sure he is safe but that they should not talk to him until he has finished his 'burn-up-speed'.

6. Artistic Flare

Because Jack is very good at drawing and wants to be an artist we talked about how Jack could draw a picture about how he is feeling to help get it out and help him to feel calmer. We talked about how many great artists use strong feelings like being angry or stressed to help them create their master-pieces! We talked about how Jack could draw in different ways to show how he is feeling.

7. Chima Count

Jack told me how Lego Chima was his favourite thing. I explained that some people find it helpful to count to 10 when they feel angry or stressed. We decided that instead of counting to 10 Jack could try and list all the names of the Chima characters. This will help distract Jack from the thing that has made him feel stressed.

8. Helpful Thought Missiles

We talked about how everyone gets thoughts that come into their head all the time. We said that some of these can be not very nice and can make us feel stressed. We talked about how Jack could practice catching these 'unhelpful enemy thoughts' like 'my picture is rubbish' and 'shooting' them down with 'helpful thought missiles' like 'this is not my best picture but that's ok, not all of my pictures need to be my best one'.

Case study IIII:

Cultural adaptations to CBT for treating OCD in a 71-year-old Muslim lady

Supervised by: Dr Patrick McGuinness

Croydon Older Adults Psychology and Psychotherapy Service

Case Study IIII: Contents

4.1 Introduction

4.1.1 Obsessive compulsive disorder and cognitive theory

Obsessive Compulsive Disorder (OCD) is an anxiety disorder characterised by obsessions, which are recurrent, persistent and unwanted intrusive cognitions (thoughts, images, urges, doubts) and overt or covert compulsive behaviours, which the individual feels compelled to enact (DSM V, 2014). For a diagnosis the obsession and/or compulsion must cause distress and/or interfere with the person's life and activities (American Psychiatric Association, 2013). CBT theories and resulting OCD treatment protocols assume continuity between unwanted intrusions found in healthy populations and clinical obsessions that characterise diagnosable OCD. This dimensional assumption is critical to the CBT model as it proposes that obsessions arise from faulty appraisals and maladaptive control efforts (compulsions) that seek to neutralise naturally occurring intrusive thoughts (e.g., Clark, 2004; Rachman, 1997, 1998; Salkovskis, 1985, 1989).

4.1.2 OCD and culture

Obsessions and compulsions transcend time and culture, consequently OCD is observed across cultures (de Silva, 2006; Rachman, 2003). OCD's epidemiology is quite consistent across countries (Horwath & Weissman, 2000). Results from 15 clinical samples from different continents suggest that cultural variation has minimal influence on lifetime prevalence rates, which range from 1.9% in Korea to 2.5% in Puerto Rico (Fontenelle, Mendlowicz, Marques, & Versiani, 2004). Interestingly, such accounts also indicate relatively consistent phenomenology across different cultures, providing further evidence for the universality of OCD (Weissmann et al., 1994; Clark & Inozu, 2014). For example, in most clinical samples contamination, doubt, and harm/aggression are the most common obsessional themes, whereas washing and checking are the predominant compulsions (Fontenelle et al., 2004).

Theorists however (Clark & Inozu, 2014; de Silva, 2006; de Silva & Rachman, 2004; Steketee, Quay & White, 1991) argue OCD is not entirely free from cultural influences and outline how culturally specific concerns and characteristics are reflected in the way obsessions and compulsions manifest (Fontenelle et al., 2004). Much however, remains unknown about the extent and significance of cultural influences in the aetiology and

treatment of OCD. de Silva (2006) highlights several ways in which cultural factors may be significant in OCD and outlines subsequent implications for clinical practice.

4.1.3 The influence of religion

De Silva (2006) and Rachman (2003) posit that religion influences the presentation of OCD because religion represents, and to some degree determines an individual's major beliefs and concerns, which directly impacts on obsessions and compulsions. Several empirical studies investigating OCD in particular cultural settings have reported a link between the presentation of OCD and religion. For example studies conducted in Muslim cultures (Okasha, Saad, Khalil, El-dawla & Yehia, 1994 (Eygypt); Maghoub & Abdel-Hafeiz, 1991 (Saudi Arabia)) have shown that obsession content often reflects religious themes (e.g. cleanliness and contamination) and compulsions often take the form of religiously symbolic practices (e.g. praying, washing).

In addition to influencing the content of obsessions and compulsions, Rachman (2003) has argued that religiosity, characterised by rigid and strict adherence to a moral code, might contribute to the overvaluation of thoughts, a key maintenance factor in OCD. An individual, for example, may view experiencing a 'bad' intrusion (e.g. unacceptable sexual acts) as being as sinful or immoral as actually committing the act ('Moral Thought-Action Fusion', Shafran & Rachman, 2004). This invests significance to the thought, which results in distress and leads to the thought becoming a persistent and recurrent obsession. Strong religiosity may therefore serve as a potential risk factor for OCD (Rasmussen & Tsuang, 1986) and several cross-sectional studies report positive relationships between religiosity and maladaptive beliefs relevant to OCD (Obsessive-Compulsive Cognitions Working Group [OCCWG], 2001), including overvaluing responsibility, perfectionism, and the importance and control of thoughts (Abramowitz, Deaconi, Woods, & Tolin, 2004; Nelson et al., 2006).

4.1.4 The likely impact of culture on treatment seeking

Since persistent intrusions are often morally or physically repugnant, they can cause great shame in the individual (de Silva, 2006), particularly when in the form of vivid imagery (Rachman, 2007). This is especially likely, as individuals with OCD tend to overestimate their responsibility for intrusions and believe that experiencing them says something meaningful and negative about them. Experiencing such intrusions may be more concerning for an individual from a more conformist culture, with higher religiosity, as they may fear others will make negative judgements about them as a result. This may be compounded by the lack of understanding of mental health problems and subsequent stigma observed in many cultures (James & Corrigon, 2012), which may make individuals less likely to reveal their struggles and seek treatment.

4.1.5 Implications for clinical practice

De Silva (2006) highlights the need for cultural competence (Papadopoulos, Tilki & Taylor, 1998, see figure 1) when diagnosing OCD in people from the non-dominant culture. This is arguably necessary to avoid labeling culturally accepted rituals or beliefs as manifestations of OCD, because they differ from that of the dominant culture and are not readily understood by the clinician. De Silva (2006) asserts that clinicians need to carefully ascertain whether the obsession and/or compulsion cause real impairment in functioning and/or genuine distress for the person. This requires a detailed understanding of the individual's beliefs behind the obsession/compulsion and comparison with what would be an accepted level within their culture of origin (de Silva, 2006).

In terms of treatment, there is little explicit guidance on how to adapt CBT for OCD to account for cultural influences (De Silva, 2006). Rachman (2003) however highlights key cognitive behavioural strategies, which can be employed to aid discussion of cultural and religious concerns, to facilitate the individual's understanding of how these are linked with their obsessions and/or compulsions. These include: ensuring that the basis of the patient's beliefs and assumptions are fully explored, discussing 'evidence' for and against beliefs and their assumptions, as well as encouraging alternative accounts of the presence of the obsessions.

Some cultures attribute greater significance to personal control and responsibility than others. Such cultural factors may need to be incorporated into cognitive reappraisal

techniques to aid treatment effectiveness (De Silva, 2006). There may also be culturally determined misconceptions around what psychological therapy involves. For example, the client may adopt a passive role because they associate the clinician with the role and practices of a 'healer' within their culture of origin. The patient's ability and willingness to accept and engage in treatment is, to some degree, influenced by their culture's attitude to therapy. This may mean that the individual requires explicit education around the role of a clinical psychologist and the methods of therapy.

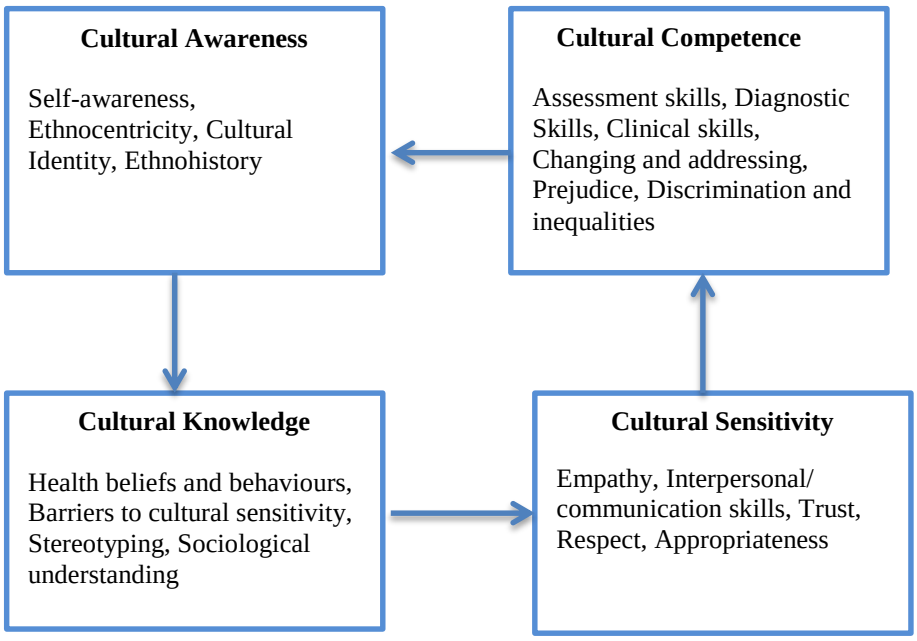


Figure 1: Papadopoulos, Tilki and Taylor model for development of transcultural competence (1998)

4.2 Aim

This case study details the treatment of Obsessive Compulsive Disorder (OCD) in a 71-year-old Muslim woman of Pakistani origin, using Cognitive Behavioural Therapy (CBT). The adaptations made to standard OCD CBT treatment protocol, to account for her cultural background and religious beliefs, are discussed.

4.3 Design

Measures of core symptoms were administered at the beginning, middle and end of treatment to evaluate treatment effectiveness.

4.4 Case description

4.4.1 Personal history

Bibi (re-named for purpose of case study) was a 71-year-old lady of Pakistani origin who had lived the majority of her early life in Kenya. She married at the age of 24 and had three children. Her husband immigrated to the UK shortly after the birth of their first child to study and she joined him in the UK a few years later. In the UK Bibi lived with her husband's extended family and throughout her life fulfilled the role of caregiver for the family network. Bibi also worked in the family business alongside bringing up her children. Bbibi's husband died 7 years prior to the current referral and her son, daughter-in-law and grandson moved in with her after his death. Bibi was of strong Muslim faith and had played many care giving roles within her community.

4.4.2 Past treatment

Bibi had initially sought treatment after post-natal depression and the onset of OCD symptoms. She had only been offered medication, which she tried for years with limited effectiveness and ECT, which she declined. She was also taken on multiple religious pilgrimages and to see 'healers' throughout her life in an attempt to cure her OCD symptoms.

4.4.3 Referral and assessment

Bibi was referred to the community psychology service by the community mental health team for psychological assessment of OCD symptoms and depression, to establish whether she would benefit from psychological treatment. She was initially assessed with her son present, who was keen to be involved in his mother's treatment. We discussed how initially it may be more helpful for his mother to receive individual CBT for her symptoms of OCD, in line with evidence based recommendations (NICE guidelines, 2005) and that if there were remaining systemic issues at the end of this treatment then family therapy could be considered. Extended assessment of Bibi's OCD was required to ensure that her obsessions and compulsions caused her real impairment and genuine distress and that the influence of cultural and religious factors were fully integrated into

the formulation (De Silva, 2006) which was collaboratively developed with Bibi over 3 sessions.

4.5 Formulation (see figure 2)

4.5.1 Triggers

The current episode appeared to be triggered by Bibi's recent retirement, consequent reduction in meaningful occupation and increased time in the family home, which she cohabited with her son, daughter-in-law and grandson. Hostility between Bibi and her daughter-in-law also appeared to play a significant contributory role in Bibi's deterioration in mental state.

4.5.2 Intrusive images

Bibi described experiencing distressing intrusive images continuously since the birth of her second child. She explained that during times of stress the images were exacerbated, becoming more intense in frequency and severity. The current episode was accompanied by depression and increased anxiety symptoms. Bibi explained that her intrusive images involved physical harm coming to babies/her grandchildren (e.g sharp objects being forced into their head) and objects being inserted into her body (e.g sharp corners forced into her vagina).

4.5.3 Unhelpful misinterpretations of intrusions

Bibi expressed the belief that the intrusive images were due to a curse passed onto her because her great aunt had experienced multiple miscarriages and died in childbirth. She had made this link because the images involved babies. She also endorsed the belief that the images were 'Shaitaan'/evil/the devil, trying to take over her, sway her from the good Muslim path, force her to go crazy and enact the images. The images made her question weather she experienced the 'bad' images because she liked them and wanted them to happen. This made her believe that she was a bad mother and grandmother.

4.5.4 Maintenance factors

4.5.4.1 Mood

Although the severity and frequency of her intrusive imagery varied over time, this increased when she was under stress or lower in mood.

4.5.4.2 Hyper-vigilance

Bibi had become hyper-vigilant for triggers for her intrusive images, such as sharp corners and objects, which had led her to notice them more, leading to more intrusions.

4.5.4.3 Avoidance

Bibi outlined how she experienced more intrusive images when she was alone and not engaged in activity. She described trying to minimise the number of intrusions by constantly keeping as busy as possible and avoiding being alone. She also described avoiding things that were more likely to trigger intrusions such as graphic imagery. Avoiding in this way maintained her anxiety and misinterpretations by preventing her from realising that her worst fears did not materialise.

4.5.4.3 Safety seeking behaviours

Bibi developed numerous ways of managing her intrusive images and the distress they caused her over the years, such as keeping very busy, attempting to maintain proximity to others, trying to control when the images occurred and using prayer to neutralise the images. Although these may have reduced her anxiety in the short term, in the longer term they served to maintain her OCD by reinforcing unhelpful misinterpretations about the power of the images and her responsibility for them.

4.5.4.4 Worries

Worries about living alone in the future were also a major concern for Bibi. As she believed she would not be able to keep busy and would experience more images, enabling Shaitaan to take over her and force her to enact the images.

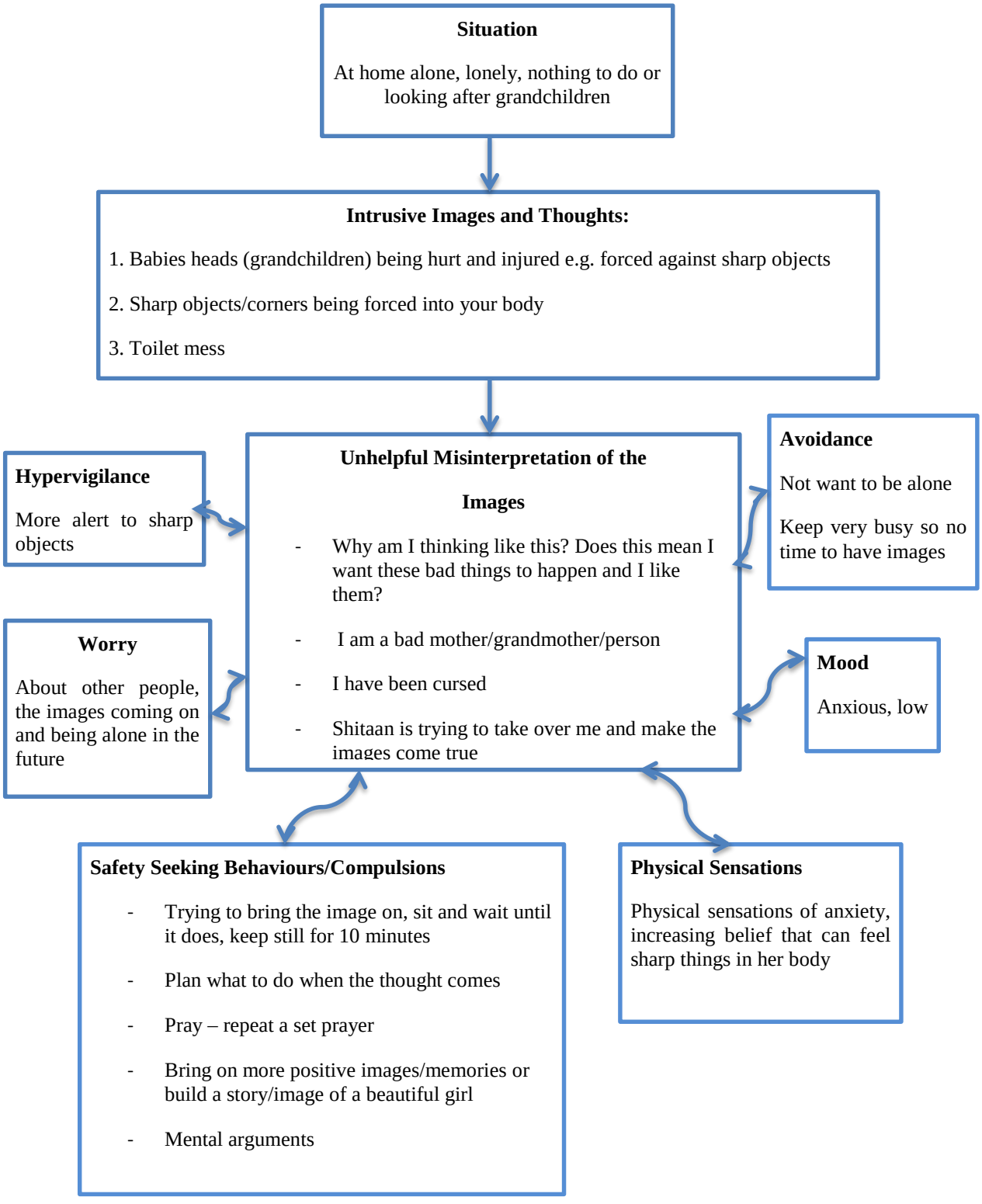


Figure 2: Formulation

4.6 Summary of treatment and adaptations

Bibi received 12 sessions of CBT for OCD. Key cognitive strategies were employed to aid discussion of cultural and religious concerns to facilitate her understanding of how these were linked to her obsessions and compulsions. Firstly, extended formulation was employed to fully explore her cultural beliefs and assumptions about her OCD symptoms. This CBT formulation enabled Bibi to view her OCD symptoms from a different and less threatening perspective. This was supported through the normalisation of the occurrence and content of intrusions, whilst emphasising their irrelevance to further action (Veale, 2007). Bibi was presented with a list of intrusions drawn from a community sample and clinical examples to achieve this. Socratic dialogue (Clark, 1998) was employed to link her distress from experiencing the intrusions, to beliefs around mental health and intrusions in her community. This revealed the cultural belief that intrusions are 'Shaitaan/the devil, trying to take over the individual and sway them from the good Muslim path, which must be resisted by the individual.

A shared treatment rationale was developed by contrasting two competing theories explaining her OCD, a method termed "Theory A, Theory B" (Salkovskis & Kirk, 1997, Clark et al, 1998). This contrasts the client's current appraisal of intrusions 'Theory A', that she is a bad person and wants the images to come true and is therefore responsible for harm coming to others with 'Theory B', which demonstrates the therapist's perspective that it is a worry problem (as she worries about being a 'bad' person and causing harm to others). Bibi was supported to evaluate the evidence supporting each theory (table 1). This process helped Bibi to see how she was living her life as if 'Theory A' was true and reported she believed this 70%. I explained that I believed 'Theory B' was 100% true and as only one could be true, treatment would involve gathering evidence and evaluating which theory is best supported (e.g. Theory B) and encouraging her to develop an alternative, less threatening account of the presence of her obsessions (see table 1).

The remainder of treatment focused on exposure and response prevention and developing behavioural experiments to test out the power of 'Shaitaan' to make her go mad and enact the images and what happened if she ignored 'Shaitaan' and did not respond to the

intrusions. The psychological perspective enabled Bibi to understand and subsequently drop unhelpful maintenance processes and safety behaviours such as keeping very busy and having to respond to the images in effortful ways (i.e. repeating them, changing them, and pushing them away). Bibi was then supported to practice responding to the intrusions in a more adaptive way, by learning to tolerate the intrusive images as part of normal imagination and that they require no further action. This was supported by the use of 'mindfulness' techniques, by letting the image occur and using a stream analogy to let them drift in and out of her mind without her acting on them. Bibi developed a cue card to prompt her to respond to intrusions in a more helpful ways (figure 3). By the end of treatment her belief in theory A had reduced to 10%.

To reduce her overall anxiety Bibi was also taught various CBT stress reduction and relaxation strategies. To manage her low mood we set value based goals which did not focus on keeping busy or pleasing others and put these into practice through behavioural activation. The negative impact of family dynamics on her mood was also discussed and problem solved to help reduce her tendency to ruminate on these issues. Bibi was supported to develop a staying well plan detailing the strategies learnt during treatment and how to continue managing her symptoms to support her recovery. She was also referred to a group course of mindfulness to support her to manage her ongoing symptoms of anxiety and depression as she expressed an interest in the benefits of this approach and meditation and responded well to mindfulness techniques employed within her individual treatment.

THEORY A	THEORY B
'I get upsetting images because I am cursed and Shitaan/evil is trying to take over me and make the images come true' This means I am different to other people and being swayed away from the good Muslim path'	'I WORRY that having upsetting images means that I have been cursed and Shitaan/evil is trying to take over me, make me go mad and act out the images'
EVIDENCE - Because I get 'dirty' or 'evil' thoughts/images I am cursed - I was cursed because my nanny had babies that died and this has passed onto me so I get these 'evil' images - Friends tell me to go to the priest because of my 'evil' images - Shitaan/evil is trying to take me off the good Muslim path by making me have these evil images and getting in the way of my prayers and reading the bible - A belief in Karma – bad things means bad things will happen	EVIDENCE - I am a worrier - I get more images when I am stressed or low in mood - Lots of other people in my community are taking medication for mental health problems but they are not well understood which makes them hard to talk about openly and honestly - Even when I do lots of good works the images still come on - I have been on religious pilgrimage and tried to 'cure' the images and the curse but this had not worked – usually they do if it is a curse - I get more images when I am alone and not busy or worrying about being alone and less busy in the future - I have never acted on any of the images - I am more concerned about my grandchildren's welfare because of the images, which makes me more protective of them - I can change the images and bring them on so I have more control over them than if they were a curse

Figure 2: 'Theory A, Theory B'

Unhelpful ways of responding to the images – **STOP DOING**	More helpful ways of responding to the images - **START DOING**
- Having an argument with myself in my head or with Shitaan - Questioning why I am getting images and trying to find an answer - Sitting still and trying to bring the image on - Planning how to respond to the image - Repeating a phrase or a prayer in response to the images/thoughts - Bringing on positive memories or the story of a beautiful girl - Keeping very busy - Trying to be with other people and avoiding being on my own	- Name the images as OCD or Shitaan, - Relax you don't need to respond - Ignore the image or imagine it is just a film playing - Remind yourself it is just your imagination - Just let the image come into your mind, stay as long as it needs and then leave your mind - Imagine the images as pieces of rubbish in a stream in your mind and watch them come in to your mind, float around and then fall off a waterfall as they leave your mind

Figure 3: Cue card for responding to images

4.7 Evaluation of treatment effectiveness

Bibi reported that the treatment intervention led to a reduction in the frequency of her intrusions and the level of consequent distress she experienced. This was also demonstrated by a reduction in her total distress score on The Obsessive Compulsive Inventory (OCI; Foa et al, 1998) from 6, at first session, to 2 at the final session (table 3). Although a recent study indicates that the OCI is valid for use with older adults (Calamari et al., 2014) the disparity between the levels of clinical symptoms displayed and reported by Bibi and her self-report on the OCI suggests that it was not a valid representation of her clinical symptoms. This is because the OCI's cut off for clinical caseness is 60 and Bibi fell well below this point, despite demonstrating multiple OCD symptoms and acute distress in response, which interfered with her daily life. This is likely due to the impact of her language and culture on her interpretation of the questionnaire items, despite her being supported to complete the questionnaire.

There was also a reduction in her general distress indicated by a reduction in her scores on The Clinical Outcomes in Routine Evaluation - 10 (CORE-10) from 18 at assessment, indicating *moderate* levels of distress, to 6 at the final session, indicating non clinical levels of distress (table 1). The Geriatric Depression Scale (GDS) (Sheikh & Yesavage, 1986) also showed a reduction in depression from *moderate* levels (12/15) at assessment, to *mild* levels (8/15) at the final session. There was however no reduction in her levels of anxiety as measured by the Geriatric Anxiety Inventory (GAI) (Pachana et al., 2007) which remained at a *severe* level throughout treatment (20/20).

Table 1: Outcome measures at the beginning, middle and end of treatment

Measure	**Beginning**	**Middle**	**End**
Core 10	18 moderate distress	14 Mild distress	6 non clinical levels of distress
GDS	12/15 Moderate depression	9/15 Mild depression	8/15 Mild depression
GAI	20/20 Severe Anxiety	20/20 Severe Anxiety	20/20 Severe Anxiety
OCI (distress)	6 non clinical levels	4 non clinical levels	2 non clinical levels

4.8 Reflections

4.8.1 Family relations

It was clear from Bibi's formulation that family dynamics and systemic issues had a large part to play in her increased symptomology. Bibi explained how she had only informed her children of her mental health difficulties within the last year and described how supportive and understanding they had been. However, the impact of her difficult relationship with her daughter-in-law and the hostility she reported receiving from her whilst cohabiting with her had caused Bibi a great degree of distress, increasing her OCD, depression and anxiety symptoms. This significantly reduced when Bibi moved in with

her daughter and problem solving was employed in sessions in response to difficult interactions with her daughter-in-law to reduce unhelpful reactions and minimise conflict. Initially family therapy was considered a potential treatment option to pursue after individual work had been completed. However, at the end of her individual sessions the family issues had stabilised and family therapy was no longer considered a priority.

4.8.2 Surprises

I had assumed that implementing CBT with an older adult would be challenging and require significant adaptations, not least due to the chronicity of the presenting problem (her OCD had remained untreated for over 40 years) and the increased potential for rigid and ingrained belief systems. Bibi however was keen to engage in treatment and extremely committed to understanding her difficulties and learning how to overcome them. She attended all sessions and completed all suggested therapy tasks without difficulty. This diligence is often observed and commented on when working therapeutically with older adults, which may reflect cohort effects around respect for professionals. Bibi's dedication to treatment however superseded mere compliance as she clearly expressed a preference for psychological intervention and was very open and flexible about her religious and cultural experiences and beliefs. These combined factors meant that my assumptions that her age, cultural and religious beliefs would render CBT interventions challenging to implement, with reduced effects, null and void.

On the contrary, using strategies such as fully exploring the basis of her beliefs and assumptions through extended formulation sessions, setting up competing theories explaining her symptoms ('Theory A, Theory B') and evidence for and against these, enabled her to drop all of her safety behaviours (compulsions) earlier in treatment than expected. This enabled later sessions to focus on her co-morbid difficulties such as teaching her relaxation and mindfulness techniques to manage her anxiety, which we were able to do by drawing on her experience of meditation and prayer. In addition we were able to implement basic behavioural activation principles to overcome her symptoms of depression.

The relative ease of adapting CBT for OCD for Bibi to achieve a reduction in her level of distress made me reflect on her long wait (over 40 years) to receive an appropriate treatment intervention. This may have been due to institutional stigma, a lack of cultural competence in medical and mental health professionals, as well as self-stigma, factors

which we may believe have improved substantially over time. Arguably, these factors still act as a sizeable barrier to people from non-dominant cultures accessing appropriate mental health care and as clinicians, this needs to remain in our awareness in order to work towards culturally competent practice.

4.8.3 Challenges

Although Bibi's level of spoken English was at a level which meant an interpreter was not required, adaptions to explanation were still required to facilitate her understanding. This meant regular repetition, checks on her understanding and concrete examples were employed. Distinguishing safety behaviours/compulsions from religious acts at times required a significant level of discussion to aid my understanding of the function of the act at the time. For example, praying was only deemed a safety behaviour/compulsion if it was done in response to an intrusion to reduce distress or its occurrence and we made this explicit to aid her response.

Stigma around mental health that she experienced in her own community meant when she had tried to share her concerns with women at the Mosque she had received negative comments which reinforced her beliefs, self-stigma and delayed help seeking. This also meant employing surveys with her peers was not deemed a helpful intervention. Her role as a caregiver who felt responsible for others was linked to her vulnerability to develop OCD and her misappraisals. This was also related to her franticly keeping busy and doing things for others. Such discussion led to goals being set around her testing out doing activities just for her own enjoyment and no other purpose. This fed into behavioural activation principles to help lift her mood.

4.9 Limitations

The main limitation of the course of treatment was that the standard 12 sessions were provided in a shorter period of time than standard practice. This was because Bibi was due to travel to Kenya for 3 months and the course of treatment had to be completed prior to this as I would have left the placement before her return, meaning that she would otherwise of had to go back on the waiting list to receive the rest of her treatment sessions. This was accomplished by having two treatment sessions a week. Consequently, treatment was more intensive than usual, spread over less time, which is likely to have

both negative and positive effects. Her trip also meant that there was no possibility for a review session. To account for this and her residual anxiety symptoms I placed her on the waiting list for a group course of mindfulness so that she would be seen by services on her return to review her symptoms and recovery and build on the coping skills she had already developed in individual treatment.

4.10 References

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4.11 Appendix:

Appendix A: Measures

CORE-10

The Clinical Outcomes in Routine Evaluation – 10 (CORE-10) is a short version of The Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM; Evans et al, 2000). The CORE-10 is a self-report measure that covers anxiety (2 items), depression (2 items), trauma (1 item), physical problems (1 item) functioning (3 items - day to day, close relationships, social relationships) and risk to self (1 item). The measure has 6 high intensity/severity and 4 low intensity/severity items. A score of 10 or below denotes a score within the non-clinical range and of 11 or above within the clinical range: mild distress (11 to 14); moderate distress (15 to 19); moderate-to-severe (20:24) and severe (25+).

OCI

The Obsessive Compulsive Inventory (OCI; Foa et al, 1998) is a 42-item self-report measure. The OCI measures the frequency of a broad range of obsessions and compulsions (Total Frequency scale) and associated distress (Total Distress scale). For each item a rating is made for frequency and also for associated distress over the past month. A cut-off score of 60 on the Total Distress scale is considered to be clinically significant. The items are divided into seven sub-scales: Washing, Checking, Doubting, Ordering, Obsessing, Hoarding and Mental Neutralizing. Each item is scored for frequency on a five-point scale, ranging from 0-4 (0 = Never and 4 = Almost Always). Each item is also scored for distress on a five-point scale, ranging from 0-4 (0 = Not at all and 4 = Extremely). Each score is presented as a mean out of a possible maximum of '4' with higher scores indicating greater distress. A mean score of 2.5 or more in any of the subscales suggests the presence of OCD. The tool is not diagnostic, nor does it categorise the severity of OCD specifically (i.e. it does not specify cut off points for mild, moderate or severe OCD).

GDS

Pachana et al (2007) created a reliable, valid and easy-to-use instrument for anxiety that is specifically targeted at older adults. The Geriatric Anxiety Inventory (GAI) consists of 20 "Agree/Disagree" items designed to assess typical common anxiety symptoms. The

measurements of somatic symptoms with the instrument are limited in order to minimize confusion between symptoms common to anxiety and general medical conditions. Pachana et al.'s (2007) initial analysis of the GAI, using a large group of community-dwelling older adults, yielded Cronbach's alpha coefficient of .91. Scores on the GAI were found to be significantly correlated with a number of other popular anxiety measures. They also tested the GAI on a smaller sample (n = 46) of older adults receiving psychiatric services. These results showed that GAI scores were not significantly correlated with age, gender, or cognitive function. In this sample, the GAI was also shown to have high test- Re-test reliability (rp = .91) and inter-rater reliability (rp = .99).